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Address.

ADDRESS BEFORE THE WORCESTER DISTRICT SOCIETY, OCTOBER 12, 1921.

BY E. H. TROWBRIDGE, A.B., M.D., F.A.C.S., WORCESTER, MASS.

MR. PRESIDENT, HONORED MEMBERS OF THE MASSACHUSETTS MEDICAL SOCIETY AND FELLOW MEMBERS: At the September meeting of the District Society, held in Worcester, some reference was made by the Chairman of a special committee, as to the lack of harmony amid the medical profession, as gleaned by him from a large correspondence with the various members of the Society.

In view of this fact, the speaker was invited by the President to present this paper, embodying the relation or duty of the physician to himself, to his confrères and to the public at large.

First. The duty of the physician to himself. This is a time when the medical schools, more than ever before, are giving to their students the most wonderful opportunities for laboratory, clinical and experimental research, for the sole purpose of producing a well-educated, thoroughly trained and accomplished practitioner in the art of the practice of medicine and the science of surgery.

Coupled with all this preliminary, is the hospital experience, which is of inestimable value. The last résumé of medical students for the year ending June 30, 1921, including pre-medical, special and post-graduate, was 14,872, an increase of 784 over last year. 14,033 were in regular colleges; 440 were in homeopathic; 98 in eclectic and 30 in nondescript colleges. I mention these figures to show how many are preparing to enter the profession and need ethical instruction.

In the examination held in Boston, March 8-10, 1921, by the Massachusetts Board of Registration, 13 subjects were covered, including 70 questions. An average of 75% was required to pass; of the 47 candidates examined, 18 passed and 27 failed, and so the medical student of today enters the profession thoroughly equipped for vast achievements.

During all this preparatory life there was always some one professor or some instructor or some practitioner, who stood out above all others as both the ideal and the idol to emulate. I presume every person in this audience pictures in his memory some one of his beloved instructors. I crave your indulgence in making the following personal reference. It was my good fortune in student days to be stimulated in anatomical studies by Frederick Henry Gerrish, that accomplished anatomist and surgeon; to serve under the skilled surgeon, the late Stephen H. Weeks, and later on with that versatile, and peer of gynaecologists, the late Seth C. Gordon, and, finally, in post-graduate course, under that prince of men, the late Maurice H. Richardson. Do you wonder why I mention these men? They were peers in the

profession—they taught, preached and practised the ethics of the profession; they were beloved by mankind; they were worthy to emulate.

In medicine, in law, in the clergy, in industrial life, there is the ethical side which is the center piece, maintaining and holding inseparable the superstructure. Without ethics, this world would be in chaos. How is it in medicine? Consulting the last catalogues from Harvard, Yale, Cornell, and the University of Pennsylvania, the subject of ethics is not mentioned or referred to.

During my membership in this Society, I have never heard read a paper on professional ethics, nor have known of that subject presented for discussion; furthermore, I have never known of the Society discussing the business side of our professional life. These two very important subjects, together with the art of dealing with human nature, should have more pronounced consideration in the medical curriculum.

Instead of the individual practising medical ethics, it sometimes appears as though the word "ethics" was unknown to the profession. The question might very fittingly be asked, "What do we mean by ethics?" My interpretation of the word is the sense of duty and the character and authority of moral obligation. It is the golden rule of the Scripture—it is the Rooseveltism of the present time.

The general practitioner of former days endeared himself, because he was the embodiment of knowledge such as was then taught; a counselor to the sick and adviser to the healthy; an advocate of all that was ennobling and beneficial to the community; honest to himself; attentive to his patients and faithful to his manifold duties.

No less so is the doctor of today, though in a different degree, because the field has so expanded that it is practically impossible to assume all the duties, as once prevailed, and hence, the various special divisions of medicine and surgery have furnished men skilled in their special subjects. By reason of this diversity, the subject-matter of ethics has assumed a more important phase and is today an all-absorbing topic.

The doctor of the present time, by reason of his education, his special training, the various and manifold facilities at his disposal to solve the perplexed problems of human life, owes it to himself to arrive at as correct a diagnosis as possible of every case submitted to him; to render an honest opinion as he views it, and give the most rational and correct advice to his patients.

Practically, there are only two questions which every patient asks, and, consequently, two answers. First, what is the matter, and second, what is to be done to relieve or produce a cure; and when the physician has honestly and conscientiously answered these two questions, he has fulfilled his duty to himself.

Second. His duty to his confrères. This division of the subject opens up, possibly, one of the most perplexing topics for consideration and discussion. We ask ourselves, "Who is our confrère?" Is every person authorized to bear the title of physician a confrère? The only version of the word that I am willing to accept, embraces those who have graduated from a regularly recognized medical school. Having, then, received the degree of M.D., the world is open before us, and the pathway unobstructed.

Mankind in all forms and phases must receive care and attention from the profession. New associations and affiliations with our confrères present themselves every day. Personal competition confronts us continually. Tact and affability strive to overcome the obstinate, the discourteous and the jealous.

Every man is a law unto himself as far as ethics is concerned, whether in dealing with his confrères as individuals, or as a group in the form of medical or surgical associations, or with hospitals, or with State and local Boards of Health, or in the so-called group medicine, or with insurance companies, or in medico-legal jurisdiction or in State insurance, or compulsory health insurance. Amid all these associations, differences of observations, opinion and judgment must necessarily arise. Because of these differences, it does not necessarily follow, but that the judgment of each and every one is entitled to due and respectful consideration and not ignominiously criticised by those not thoroughly familiar with all the data thereof.

We have all had our share of experiences, some more, some less. Only about two months ago, a former patient of many years past, and now a resident of another State, entered the office and, in course of conversation, asked me about an operation performed upon her fifteen years ago. On looking up her record, I found that she had Edebohl's operation for nephropexy. After informing her of what had been done, she politely told me that she had recently undergone an examination and in the course of such, the contracted scar was noticed and inquiry made as to the condition requiring operation, and on informing the examining doctor that she had had her "kidney sewed up," as she expressed it, he exclaimed, "I do not believe you had anything of the kind done." This remark so disconcerted the patient, that she very forcibly expressed her opinion to the consulting surgeon.

What right had this doctor to be so unethical as to express himself, not knowing anything of the condition existing fifteen years ago, except what the patient disclosed? It is just these like experiences which sow the seed of distrust and

cause the lack of harmony among brother doctors.

Mrs. B—, in 1918, was seen and examined by a very accomplished physician, who readily and correctly diagnosed the case as cancer of the cervix uteri. She was referred to the speaker. The case was so bad that an unfavorable prognosis was the only rational and justifiable opinion to give. The patient and her husband were duly informed of the true condition, and it was advised to remove all the diseased area, and then to receive the benefit of radium as the only means of prolonging life.

Due correspondence was entered into with the authorities where radium was to be given, and the case fully described, and our plan mapped out, viz.: to fulgurate all the diseased area and remove all the cauliflower growth, reach a base where the application of radium would have an immediate effect.

After the case was seen by the authorities who were to administer radium, they wrote of the hopeless condition, but would give the patient the benefit of the radium, in order to give some relief, if possible. Several treatments of radium were given, with some apparent evidence of improvement; but finally the hopelessness of the case became so manifest, that it was impossible to continue radium treatment and the patient died at one of the hospitals in Worcester.

At about the time of the last treatment, the authorities were questioned by the patient, as to the effect of the radium, in the hope of cure, and, much to their amazement (as well as to my own), for they had known of the correspondence, they replied, "Well, if we had received the case earlier, we might have been able to have done more for her than we have," leading the patient to believe that she should have been sent there long before she was, practically an impossibility,—a reflection on the previously advised treatment, and a slap to the one who referred the patient to the hospital. Such unethical demeanor was not justified.

I might cite many, many cases where patients have been given a diagnosis entirely at variance with that of their family physician, and that, too, with some unfair remark. When such is done, disloyalty to the fellow practitioner is shown, and, too, the patient is not treated fairly in the eyes of those she may have previously consulted. On the other hand, it is not right to tell a patient that a mass in the breast does not amount to anything, when it is a serious question as to the condition being benign or malignant.

It is not right to tell the woman with a fibroid causing profuse menorrhagia, that an operation is not necessary to relieve the persistent loss of blood which is causing the anemic condition. In the various multifold relations, as before mentioned, no doubt differences among fellow practitioners will prevail, yet if the ethical feature is duly considered and practised, I feel sure that whatever lack of harmony now exists will be dispelled in the future.

It would be an enormous undertaking for the speaker to try to analyze all the various relations of the members of the profession, and attempt a rational solution of the various phases wherein lack of harmony prevails. Personally, I consider our relations at the various medical and surgical meetings to be of the most efficacious for the development of brotherly feeling; to stimulate more and more an unrestricted cooperation in all matters pertaining to the welfare of the profession. The responsibility of making meetings like this of mutual benefit, socially, intellectually and professionally, cannot be shouldered by the few officers, but must be aided by a hearty coöperation of the individual members, and that means every one of those here present, and especially applicable to those absent—without a justifiable cause.

It is at these meetings where opportunity is offered to discuss and thrash out any and all matters pertaining to the interest of the profession. We cannot shut our eyes to the new propositions, the new philanthropic endeavors, new advanced legislative measures, new theories and new discoveries in the causation and treatment of diseases, now under laboratory investigation; various excuses for evading the well-recognized and accepted health and sanitation laws.

I suppose it might be said that human nature is about the same from one generation to another. Granted that it is,—though I doubt it, the next generation of medical men will have problems to solve unheard of to those of the present generation.

During the brief seven years past, the medical profession were confronted with a situation the like of which no one mind could have ever conceived. What noble and unselfish sacrifices were made for the sake of suffering humanity; for the preservation of the Government; for the welfare of the whole world! Every physician who entered the Service, so entered because he believed it was his duty.

The wide field of experience—the intermingling with officers, both of superior and inferior rank; the varied and multifold duties requiring accuracy and punctuality; the more extensive study of disease and intimate knowledge of human nature—have contributed to make every member of this profession more charitable, and more respectful of his fellow practitioner.

It is my belief, that deep in the heart of every physician there is always present the desire to do right; to render such service as is within our power, both by word and deed, for the good and welfare of every brother doctor. Sometimes there arise innuendoes which have a tinge of jealousy. I well remember the story as related by one of the professors during my

student days. He was describing the history of the stethoscope, and held up to view two models—one, the old-fashioned wooden piece, bell-shaped at each end, and one end applied to the chest wall, the other placed snugly to the ear; the other was a bin-aural, somewhat similar to that of the present day. It so happened that among the doctors in a certain town, there was one especially progressive, and on his visit to New York, he purchased the most recently improved bin-aural stethoscope. As time went on, he naturally discarded the old style and used the improved one. One of his confrères, who had not become familiar with this improved style, being informed that Dr. A— was using this style of stethoscope, remarked, "Well, that style was made for those whose hearing was slightly defective, as both ears could secure the sounds, but when the sense of hearing was not impaired, the wooden instrument could be just as satisfactorily used." Do you believe that that remark had its psychological effect and created in the minds of his hearers the impression that possibly Dr. A— was a little "hard of hearing," as is the laity phrase? Certainly, we are truly responsible for such acts, whether affecting us individually or having a wider influence and effect on our confrères.

I once heard a noted surgeon make this comment, that in his work he was governed by the thought that he should do for his patient that which he would want the patient to do for him, if the patient was the surgeon and the surgeon the patient. So in our relation to our confrères, let us extend the same courtesy as we would wish extended to us.

If there is apathy or indifference or lack of harmony among the medical profession, it is about time that it should be dispelled. The cause, if any does exist, should be diagnosed and the remedy applied. In the near future, and perhaps I may not be so far out of the way to say that just now, there is the greatest need and demand for the profession to cooperate in the fullest extent. But how can a hearty coöperation be expected if the ethics of the profession are so ignored, or so loosely observed as to have no weight or influence at all?

In my judgment, the solution of this question resolves itself in having a code of ethics and that code lived up to. Such cases as I have cited—the individual doctor and the hospital—are being duplicated every day and you and I both know it. It may be that we are too self-centered, or think or imagine that we are infallible, or deceive ourselves that one's vast experience and knowledge tends to an assurance of superiority, and permits an expression of opinion of authority, but such a psychological attitude is not conducive to the best interests of the profession as a whole.

Third. The relation to the public at large: The influence and weight of authority of the medical profession practically dominates every community. The doctor in his individual capacity is responsible for the health of the community. We deal with three classes, *viz.:* the ignorant, the fairly well educated and finally, the educated. In whatever class the individual may be, he consulted the particular doctor because he has confidence in him, or because so directed by those who know of the abilities of the doctor and vouch for him. In other words, every doctor, so to speak, builds up his own reputation according to just such valuable service as rendered to the community as a community, or the individuals of that community.

The opportunities for so doing, however, may not present themselves as quickly or as numerously as might be desired. It takes time for a business house or firm or corporation to acquire a business reputation, so it takes time for the doctor to acquire his reputation. The physician is placed on his own initiative, on his own tact, on his own judgment, in deciding what to do and how to do and what not to do.

The young graduate of the present era is obliged, like his predecessors, to abide his time, unless pushed ahead by senior associations cr by hospital affiliations, or by such varied means as contribute to his advancement. Suppose, however, he enters the community unheralded and unknown. What, then, is the ethical method of procedure to ingratitate himself in the community?

The business side is all-important, unless the physician is not obliged tc depend upon his meager income for support. Many a prominent man in the profession has had a stormy entrance into medical success.

This opens up the great question of ethics, for, in the near future, I fully believe that the profession will be so listed in *that* form acceptable to the Medical Society as sponsor, indicating what is the particular or special subject the doctor is to devote his time and practice. If you look through the last *Directory* of the city of Worcester, you will see a list of the members of the Massachusetts Medical Society—Worcester district,—but by that list every doctor is alike to the reader; no indication as to whether in general practice or special department.

If it is sometimes difficult for us to select for a patient some one in a special line, how much more difficult for the average citizen to make a selection of a specialist?

I would even advocate that the doctor's name in the telephone directory have appended the special designation of his line of practice, duly sponsored, however, by similar registration with the Secretary of the Medical Society. By so doing, the ethical feature is not trespassed upon; the community can become familiar with the various physicians in special work, and can be depended upon because of the sponsorship of the Medical Society.

The professional attitude to the patient is probably the first consideration, and that can be summed up in a very few words, *viz.*: to render the best service that lies in one's power to give, that service rounded out by knowledge and valuable experience.

The next phase—*the business or financial aspect*. I do not believe that any man ever entered the medical profession allured by the thought of large financial returns. The profession is entered because of love and personal adaptation for it, but after the long training is finished, then the financial side has a very necessary and important bearing to the large majority. The business attitude toward the patient should be governed by his situation in the business world and the value of the services rendered in his behalf.

What shall be the attitude, however, toward various corporations where the doctor is only sent for in grave emergencies or severe infections, and someone else, other than the doctor, assumes the other responsibilities of treatment? What about the attitude toward insurance companies, who ask for the report of cases, without any remuneration, when the patient has, on his own volition, consulted you for treatment? What attitude of the profession toward legislative measures, such as the Sheppard-Towner bill and other measures affecting the just rights of the medical profession?

Are we, as a body, to "sit tight," so to speak, and allow someone else to engineer legislation unfavorable to the profession? Do you realize what valuable services one of our members, Dr. S. B. Woodward, rendered to the Massachusetts Medical Society when he occupied the presidency two years ago? That the profession is rendering valuable service to the community, I need cite only a few instances, and among the most notable is the efficient work of Dr. Copeland, the Health Commissioner of New York, whose administration is a marvel of the present decade. Also, Dr. Harris, the Deputy Commissioner of Police, who has devised and laid out a traffic system that is saving New York endless inconvenience, annoyance and time; Dr. Carlton Simon, Deputy Commissioner of Police, in charge of the narcotic bureau, has had a herculean task, but has met the situation with marked courage and ability, and has handled the problem with such energy and intelligence as to receive universal commendation. The nefarious schemes of the narcotic crooks are being squelched and the community protected. Dr. Chandler, the commanding officer of State Constabulary, is equally efficient in his field and has displayed wonderful administrative ability, tact and skill. That Dr. Herbert Work, the president of the American Medical Association, has been appointed an assistant Postmaster General, is another tribute to the medical profession.

What about our attitude to the various cults that are striving for public recognition? What is our attitude toward the propaganda recently issued by the trustees of the Johns Hopkins Hospital? What a slap to their own hospital staff, as well as to the profession in general, in trying to establish a maximum fee for operations and a weekly fee for hospital attendance.

Think you that the trustees of this or any hospital would relish the idea that only a limited amount of money could be given or willed to their respective institutions when today every hospital is in need of extra funds? It is just as unreasonable and inconsistent to limit the professional fee by any board of trustees (hospital) as for the Bar Association to limit an amount for a retainer for any of their members. The time is coming when the members of all hospital staffs will be paid for their services.

What is our attitude toward the anti-vivisectionists? "The Truth about Vivisection." We quote the following from *Science*, Sept. 16. In the *Woman's Home Companion* for July, 1921, is the best paper on this subject I have ever seen, called "The Truth about Vivisection," by Mr. Ernest Harold Baynes. Mr. Baynes first read the literature on both sides, and then visited practically all the laboratories from the Mayo's at Rochester, Minneapolis, to the eastern seaboard. He visited, especially, the Rockefeller Institute several times, also a number of European laboratories. He became thoroughly convinced (1) that the experiments were not cruel; (2) that the statements in the literature of the anti-vivisectionists were often garbled and utterly misleading; and (3) that the results to animals themselves, as well as to human beings, were of enormous benefit. Then he wrote the article, and Miss Lane, the editor of the *Companion*, bravely printed it.

The especial significance of his writing such an article lies in his nation-wide reputation as a lover of animals and their protector. He is the father of all the bird refugees in the United States. His lectures on animals have been heard everywhere, and when he approves of the experiments on animals, everyone knows that he has good reasons for doing so.

The fury of the anti-vivisectionists at once rose to fever heat. The New York Anti-Vivisection Society, through its president, Mrs. Belais, sent out an extraordinary appeal calling him "One Herbert Harold Baynes," almost as if one should write, "One Herbert Hoover." In a paragraph, all in capitals, Mrs. Belais called on all lovers of animals to help crush Miss Lane financially, not only by canceling their own subscriptions, but by urging all their friends to do the same,—a nation-wide boycott.

This extraordinary method will ensure a reaction in favor of Miss Lane because of its vindictive unfairness. It is not argument; it is persecution, and it is illegal.

Mr. Baynes has also been attacked by mail and by cancellation of engagements. It is up to us to sustain so doughty a champion. He has given

the anti-vivisectionists the hardest blow I have ever known in forty years. (W. W. Keen.)

What is the professional attitude toward anti-vaccinationists? Read the valuable articles in the BOSTON MEDICAL AND SURGICAL JOURNAL, August 25 and September 15, and anyone in doubt will certainly be convinced of the efficacy.

There is one aspect of our relation to the public at large which would require more than one evening to consider and discuss, and I cannot attempt to go into it, but only mention that aspect, and that is, the applied psychology to medicine and surgery; see to it that what we say is thoroughly understood and not misconstrued; that our acts are not misjudged; that our recommendations are correctly interpreted; that whatever comment is made is free from unfairness.

In this Commonwealth it is estimated that there is three and one-half million of population and over six thousand registered physicians. Is there any class other than the physicians that render the community such valuable service without compensation in hundreds and hundreds of cases? Does the community appreciate the sacrifices many times made by the physicians in administering to the multifold needs of this vast population?

It would seem sometimes that no thought of appreciation is conceived by the public of what the doctors are daily doing for the health and welfare of those who frequent the large number of hospitals throughout the State where the services are gratuitously given. In recognition of this service alone, the State owes the medical profession a protection of their just rights against their encroachment, by legislative action, favoring various cults and other scheming bodies, to impose upon the people of this commonwealth. Sometimes at the State House it appears as though the medical profession was without a single friend when these various matters are being considered. The time is ripe to convince the public that the medical profession is working for their interests in thousands of ways. It devolves upon the Medical Society and various members to cement a closer tie between the medical profession and the public. That the all-important problems to solve: *first*, how can that be accomplished; *second*, what must be done; and *third*, how can the Medical Society have more influence?

The first can be answered by taking the public into our confidence, and prevent their being alienated from the honest and loyal practitioners, by all sorts and forms of quackery, under disguised names, knocking at the legislative doors for recognition. Second, the profession must act as a unit, to protect its own interests and rights, and not show any luke-warm interest in those matters that are of a public nature. Third, the society can have more influence if the members of the profession assumed more individual responsibility in public affairs.

That feature presents the apprehension that it will detract from the doctor's professional standing; hence if such apprehension can be dispelled, then the field is open to the profession to render still greater service to the public at large.

In conclusion, I would favor a printed code of ethics placed in every doctor's office, so that it can be seen and read and not tucked away in some obscure corner or secreted in some never-opened drawer; this would dispel any misunderstanding or ignorance on the part of the public as to the ethical relations of the medical profession. I would favor the enrollment of every physician in the regular city directory and telephone directory, under the sponsorship of the Medical Society, of their special department of medicine and surgery. I would advocate the more general participation in general public affairs.

I hope that you will pardon me if I have trespassed on your time longer than I intended. I do not wish to appear in the slightest degree too critical—that would be very unbecoming to anyone of us—but I do appeal for a hearty and fraternal co-operation among the members of this noble profession, remembering that a man who does his duty, honestly and sincerely, will be looked upon by his fellow-men with honor, respect and admiration.

The New England Surgical Society

EXPERIENCES WITH TUMORS OF THE SPINAL CORD.

BY W. J. MIXTER, M.D., BOSTON.

Assisting Surgeon, Massachusetts General Hospital.

DURING the past ten years it has been my good fortune to care for a number of cases that come under the heading of cord tumor. Strictly speaking, only a small part of them are tumors of the spinal cord, but all of them show definite cord symptoms. Perhaps a more exact definition of the group would be cases of apparent chronic cord compressions of non-traumatic origin. One of the main reasons I wish to present this group at this time is the great variety of diagnoses met with, which may give the symptom complex which we associate with cord tumor.

The group comprises some fifty-four cases, and some twenty-one different pathological processes were encountered (Chart No. 1). I have been able to keep in touch with all these patients so that the end-result, or rather the present condition of the patient, is known in each case. In analyzing this series, we find that it may readily be divided into four groups, depending on the structures primarily involved, as follows: (1) Lesions of the cord itself; (2) Lesions of the nerve roots and meninges; (3) Lesions arising in the spinal

CHART 1

	Incidence of operation			Immediate results					Untreated cases			Late Results				
	Total number	Laminectomies performed	Operative—death	Operative—lesion found	Operative—lesion not found	Improved	Unimproved	Died in hospital	Number of cases	Died in hospital	Well	Much improved	Slightly or temporarily improved	Unimproved	Died from intercurrent disease	Died from the lesion
Lesions of the cord																
Glioma	4	4		3		1	2		1	1			1	2		2
Intra medullary cyst	2	2		2			2						1		1	
Cholesteatoma	2	2		2		2						2			1	
Tuberculosis	1	1			1			1								
Syphilis	1	1		1			1									1
Varix	1	1		1			1							1		
Tumor of membranes and nerve roots																
Arachnoid fibroma or endothelioma	4	4		4		3	1				1	2	1			
Dural cyst	1	1		1		1							1			
Fibrosarcoma of dura	1	1		1		1						1				
Neurofibroma	4	5		4		4					2	2				
Dermoid cyst of cauda equina	1	1		1			1							1		
Fibro sarcoma of cauda equina	1	2		1		1						1				
Adamantinoma of cauda equina	1	1	1	1				1								
Lesions arising in the spine																
Enchondroma	2	4		2		2							1			1
Chondrosarcoma	1	1		1			1						2			1
Round cell sarcoma	1	1	1	1				1								
Giant cell sarcoma	1	1					1									1
Myeloma	2	2		2			2									2
Metastatic carcinoma	9	1		1		1			8				1			9
Metastatic hypernephroma	1	1		1			1									1
Metastatic leiomyoma	1	1		1		1							1			1
Tuberculosis (of spine)	3	3		3		2	1					1	1			1
Negative explorations																
Degenerative lesions of cord	5	5			5		3	2						2		1
Pathology unknown	4	4			4		4							2		2
Totals	54	50	2	34	10	19	21	5	9	1	3	9	10	8	2	23

Spinal Cord Tumor Cases

column; (4) No lesion found at operation. Group 1 shows eleven cases with unsatisfactory results, but this is rather to be expected, as many are intra-medullary lesions, whose removal is impossible.

The cases falling in Group 2 are our prizes, for here we find, for the most part, encapsulated tumors and, moreover, tumors which can be enucleated without danger to the spinal cord. In this group I have three cases which may be classed as well as they are without subjective symptoms, function is perfect and neurological examination reveals no variation from the normal other than somewhat hyperactive knee-jerks. The tumors of this group have been encountered and removed at various levels from the cauda equina to the second cervical segment.

Group 3—Lesions occurring in the structures of the spinal column, either original or metastatic, are most unsatisfactory, owing to the great predominance of irremovable malignant disease. Here the problem becomes one of palliation and relief of pain. The bone lesions are in a large part malignant, are demonstrable by x-ray, and their most outstanding characteristic is severe pain. Relief of pressure by laminectomy is so satisfactory at times that even in these malignant cases it may be indicated.

The cases of Group 4 comprise those in which no gross lesion could be demonstrated at operation. In this group naturally fall the cases of lateral tract degeneration, combined system disease, transverse myelitis of infectious origin, etc., which at times closely simulate cord tumor. The group is quite a large one, as I have explored a considerable number of cases where tumor was a possibility, though the chances were that one of these other irremediable conditions

was the cause of symptoms. My rule at present is to operate on any case presenting signs of a definite cord lesion, even if the degenerative processes are strongly suspected. A patient with lateral tract degeneration, syringomyelia or some similar lesion, is in desperate straits, useless to himself and hopeless of cure. Two cases in which such a diagnosis had been previously made and the patient given up as incurable, showed at operation easily removable dural tumors, and one of them, six years after operation, is one of the three classed as well. She has been working steadily since nine months after operation.

Dr. J. B. Ayer has given us, with the combined puncture of the cisterna magna and the lumbar space, a very valuable means of differentiating between the degenerative lesions and those in which surgery may be successful. It is, I think, one of the most important advances in neurological study, but its use should be restricted to those thoroughly versed in the procedure. It should not be performed on every cord case, and only with a full realization of its difficulties and dangers. I have operated on some 18 cases following double puncture and have always found tumor, if indicated by puncture. I did find compression from cyst in one case where the puncture was negative. With this one exception, it has always been accurate. When these results have been confirmed by a larger series, we will be in a position to refuse operation on a considerable number of patients who now present themselves as cord tumor suspects.

Were it possible to differentiate between these different groups of cases prior to operation, as in neoplasm elsewhere, we could give a much more accurate prognosis, and many incurable patients could be spared the suffering of an unsuccessful operation. This, however, we are unable to accomplish with our present knowledge, and hence must operate on practically every case, except those in which malignant disease can be definitely proven.

Under treatment, I have little that is new to offer, for the technique of laminectomy has been well worked out. Wide exposure is essential, and for that reason short incision and unilateral laminectomy are both to be condemned. By means of careful dissection close to the bone, the muscles can be drawn aside with comparatively little hemorrhage. There is one point on which I want to lay emphasis, as in my hands it has done a good deal to shorten the operation and lessen hemorrhage. I have found that after the dissection has been completed on one side the spinous processes can be undercut close to the laminae, with heavy forceps, and turned aside with the muscles of the other side. It is necessary to undercut one spinous process above and one below the laminae whose removal is contemplated. This is done, however, without additional dissection. The interspinous ligament is preserved with the spinous processes, thus considerable dissection is avoided and a structure of great strength is retained, while the exposure obtained is just as satisfactory as if the spinous processes are completely removed. The laminae are then removed, care being taken to prevent damage to the underlying cord, particularly if it is pushed back against these structures by neoplasm lying anterior to it. Wide exposure is of the greatest importance. Careful hemostasis is now secured, and a thorough inspection of the field made before the dura is opened. At this time the tumor can usually be demonstrated either as a definite mass lying outside the dura or as a swelling within it. An extra-dural lesion should be treated without opening the membrane, unless it lies directly in front of the cord, and whether benign or malignant, an attempt should be made at its removal. If the lesion is within, or arising from, the dura, the dura is opened and the cord inspected. If the new growth is outside the cord, it should be excised at once, cutting away dura or nerve roots involved, if necessary. It is frequently possible to dissect off nerve roots that seem at first to be very deeply involved in the tumor.

Should the tumor be intramedullary, the cord is split over the tumor mass in the hope that it will extrude, and may be removable at a second sitting, as advised by Dr. Charles Elsberg. Personally, I have yet to see a successful result following this procedure, but my experience with this type of case has been very limited. Removal at once of an intramedullary tumor is not to be attempted on account of damage to the cord. Cyst evacuation is indicated and the result may be extremely satisfactory. Dr. Harvey Cushing has taught us that nerve tissue must be handled delicately and without trauma. I can only add that in the surgery of the cord, gentleness and delicacy of manipulation are essential if success is to be attained. Closure of the wound is modified by suturing muscle and fascia to the retained intraspinous ligament rather than to the muscles of the other side. The resulting scar is just as flexible as in the usual form of laminectomy and is much stronger, which must be of benefit, particularly in the cervical region.

Under post-operative care, I wish to mention the fact that plaster shells and other rigid supports are unnecessary, even in high laminectomies. The patients are much more comfortable, and the result is as good with a simple dressing. The one exception to this rule is where there is an extensive destructive process of the vertebral bodies. X-ray treatment following operation, is without doubt indicated in the gliomata as well as in the more definitely malignant growths. I have one case where an extensive infiltrating glioma of the cervical cord was exposed and the cord split

in the hope of extrusion. No further operative measures have been carried out as yet, as the patient has shown marked improvement under x-ray treatment.

The differential diagnosis of cord lesions depends on careful, painstaking neurological examination, good x-rays and the examination of the spinal fluid, as previously indicated. Cord tumors have been treated for chronic appendicitis, gall-bladder disease, and various orthopedic and genito-urinary troubles, as well as diagnoses as degenerative processes before coming to operation. In order to obviate these errors, we must have the most complete coöperation with our neurological colleagues. This I have had, and I take pleasure in thanking the Neurological Department at the Massachusetts General Hospital for the able assistance and counsel they have given me.

CHART 2

	Number of Cases	Well or Improved	Unimproved	Dead
Lesions of the Cord	11	3	3	5
Tumors of the Membranes and Nerve Roots	13	11	1	1
Lesions Arising in the Spine	21	3	1	17
No Gross Lesion Found*	9	0	4	5
Total	54	17	9	28

*Degenerative Processes, etc.

Present status of all Cases

CHART 3

	Number of Cases	Operations	Operative Deaths	Well or Improved following operation	Unimproved by operation	Now Living	Late Deaths
Lesions of the Cord	10	10	0	4	6	6	4
Tumors of Membranes and Nerve Roots	13	15	1	11	1	12	0
Lesions Arising in the Spine	13	15	1	6	6	4	8
No Gross Lesion Found*	9	9	0	0	9	4	5
Total	45	49	2	21	22	26	17

*Degenerative Processes, etc.

Operative and End results in operated Cases

In this group of 54 cases, laminectomy was performed on 45 patients, the other nine being deemed inoperable. In these 45, forty-nine laminectomies were done, with two deaths, a mortality of 4.1%. In one instance, a tumor was found at some distance from the situation expected, and operation was unjustifiably prolonged and the tumor removed at one sitting instead of being completed at a later date. The other death, a few hours after the removal of a small specimen of malignant new growth from the deep tissues of the back, was unexplained, though possibly it was from embolus. There were no other deaths that could be laid even remotely to the operation. Twenty-six patients are now living; of these, three are well, eight so much improved that they are or could be self-supporting, eight are somewhat improved, though still incapacitated, and seventeen have since died. Of these, two died of other diseases, one following definite improvement. The other fifteen have died as a result of the disease for which they were operated, or from sequelae.

In closing, I wish to point out that chronic cord compression is more common and more amenable to treatment than I, at least, had believed. Also that on careful study, a number of supposedly incurable paralytics will be found to reveal the opportunity for well-nigh marvelous surgical results, and that the risk of operation is hardly greater than in many of the more serious abdominal lesions.

DISCUSSION OF DR. MIXTER'S PAPER ON LESIONS OF THE SPINAL CORD.

DR. WILLIAM J. MIXTER, Boston: I would like to add that one of the most striking results I have seen was in a case operated on by Dr. Porter, and I hope he will speak about it in the discussion.

DR. CHARLES A. PORTER: I will speak of a case which I operated upon, while in charge of Dr. Mixter's specialty, during the war. A young boy had acutely increasing symptoms of paralysis, due to a lesion in the cervical region. I performed a laminectomy, and found enchondroma growing from the body, and adjacent lamina of, I think, the fifth vertebra, pressing on the cord. By pushing the dura gently to one side, I was able to curette away all the growth. In doing so, it became necessary to control, by packing, a severe hemorrhage from the vertebral artery. The wound was packed for a few days, and the boy made a satisfactory, and unusually rapid recovery.

DR. WILLIAM J. MIXTER, Boston: One of the particularly interesting points about that patient of Dr. Porter's which he has not mentioned was the question of diagnosis. The patient showed very definite neurological symptoms in both legs and fairly definite symptoms of increased intracranial tension. For this reason it was advised very strongly to explore his leg area on the left side, I believe. It was only discovered by very careful examination that he had a very definite atrophy of the muscles of the shoulder girdle, and then when a double puncture was done it showed a definite obstruction below the cisterna magna, and I think if the boy had not been kept under observation and had not shown this increasing atrophy of the shoulder girdle, and if cistern puncture had not been done, he would doubtless have been operated on for brain tumor with wide exploration and no tumor found.

I think this is all I have to say except to reiterate that the most painstaking neurological examination is necessary and it requires rather expert neurological advice in order to give one that painstaking examination.

Original Article.

END-RESULTS OF THE SURGICAL TREATMENT OF 48 CASES OF TUBERCULOUS CERVICAL ADENITIS.

BY FRANK H. LAHEY, M.D., BOSTON,
AND
HOWARD M. CLUTE, M.D., BOSTON.

FOR the purposes of this investigation, all the cases of tuberculous cervical adenitis at the Boston City Hospital for the five years from June, 1915, to March, 1920, and likewise all the cases in private practice of one of us (F. H. L.) were considered,—totalling 132 in number. Owing to the type of patient treated at the City Hospital and the length of time that frequently had elapsed since operation, it was possible to trace but 46 of these cases. Nineteen, or 43.4 per cent., of this series of 46 were classed as excellent results: they showed no further evidence of tubercular glands, nor did they present any of the disabilities which were found among some of the remaining cases; with the exception of the scar upon the neck, there was no evidence of the disease or its treatment.

In twelve cases, or 26.08 per cent. of the series, we found evidence of paralysis of the trapezius muscle from interruption of the conductivity of the spinal accessory nerve or the third and fourth cervical nerves. Of this group all showed a clearly marked deformity, and only three of the twelve made no complaint of the resulting disability. Two patients in this series came to the City Hospital with a paralysis acquired elsewhere.

There was no case in the series with a sinus present at the time of examination. Two cases reported sinuses draining over a year. One sinus had closed unaided, and in the other case the patient has received tuberculin.

Five cases showed a paralysis of the depressor anguli oris muscle. No patient experienced any disability from this lesion, nor did the deformity seem particularly disfiguring.

Two cases were reported as having died since operation: one patient of pulmonary tuberculosis; the other of "intestinal trouble."

Tenderness over the scar was very marked in one case. This patient had had a complete dissection of the neck. She presented a thin, wide scar and atrophy of the superficial structure over the lower carotid sheath. The vessels were plainly visible under the scar and slight pressure caused pain.

In only eight cases did we find glands persisting after the operation: two of these showed evidence of an active process in the remaining glands; these particular cases have had several recent x-ray treatments with marked improvement.

The twelve cases of spinal accessory paralysis were divided among six different surgeons, indicating the possibility of this accident occurring in any hands. In fact, it has occurred in our hands since this investigation was begun, in a patient whose spinal accessory nerve we carefully followed and preserved anatomically intact. The paralysis resulting from the dissection was possibly due to our pinching the nerve to establish its identity. As far as could be ascertained from the records, but two of these cases in which paralysis occurred were of the bloc dissection type of operation.

The problem of the treatment of tuberculous cervical adenitis has been by no means a settled one. Surgeons must admit that "bloc dissections" result in spinal accessory or third and fourth cervical nerve paralysis, with consequent functional disability, too often to permit its being resurrected from the oblivion into which it has, for the most part, sunk in the treatment of tuberculous cervical adenitis. On the other hand, hygiene, x-ray, and tuberculin are by no means the sovereign remedial measures we could wish them to be in the treatment of this condition. There exist cases in which not necessarily "bloc dissection," but certainly a very complete neck dissection will be necessary, and, on the other hand, there likewise exist many cases capable of being relieved of this condition by one of the non-surgical procedures cited above. Unfortunately, the great majority of the cases exist in the group just between these two extremes, and it is our belief that in this group combined methods, surgical and non-surgical, must very frequently be employed.

We feel, in the first place, that if prompt and active treatment could be instituted and adhered to in cases as soon as they manifest this condition, together with adequate attention to unsatisfactory conditions of tonsils or teeth, and also to other contributing factors, radical surgical measures would rarely be necessary. While we have no personal experience with the application of x-ray therapy in these cases, we have referred for this form of treatment and observed the outcome in a sufficient number of these cases to be convinced that it has a very distinct place in the treatment of this condition, not only as regards the firm, non-necrotic glands, but also for the closure of the tubercular sinuses which have resulted from the drainage of the liquefied ones. Liquefaction will undoubtedly follow radiation of some of the caseating glands, but drainage and, later, radiation of the gland shell, then become possible.

Surgery, in our opinion, should not be resorted to in tuberculous adenitis until x-ray therapy has been tried for a considerable period of time—from six months to a year—provided the disease is not spreading and involving the adjacent glands. While the disease remains confined to a few glands, nothing is lost by continuation of x-ray treatment, and we have been surprised in a few instances by

the diminution in size which occurred some considerable time after the beginning of the treatment.

Surgical removal of the glands, we believe, should be undertaken when, in spite of x-ray and hygiene (we have had no experience with tuberculin), either the neighboring glands are becoming involved, or, after fair trial of radiation, shrinkage is not apparent. We do not believe that where one or two large glands must be removed, x-ray failing, it is necessary also to remove the small, soft, non-caseous glands which surround them, but that these may well be treated by radiation.

We further feel that there exists a neglected type of tuberculous adenitis in which there is extensive involvement of practically all of the glands of the neck, and that this type is of such seriousness—not necessarily as of threatening life, but disfiguring, disturbing, and progressive—as to justify complete surgical removal even with its possibility of resultant spinal accessory or cervical nerve paralysis and its crippling functional disability due to loss of the trapezius muscle.

We do not believe that any one measure will yield satisfactory results in this condition, but that the combination of attention to infecting foci, radiation, hygiene, conservative surgery, and early attack on the condition will yield gratifying results.

Finally, we believe that whenever an extensive neck dissection for a not necessarily fatal condition is undertaken, one should have definitely in mind the possibility of spinal accessory paralysis, and that that paralysis is a serious one, limiting arm abduction to less than a right angle with the body.*

Book Reviews.

The Genuine Works of Hippocrates. Translated from the Greek, with a Preliminary Discourse and Annotations, by FRANCIS ADAMS, LL.D., Surgeon. William Wood & Co. Octavo. 766 pp.

Dr. Adams' translation of the *Works of Hippocrates* is the translation accepted by the Sydenham Society of London. In this edition, the writings of Hippocrates are carefully labelled as genuine, probably genuine, or quite probably not genuine. The works, themselves, are preceded by a Preliminary Discourse, dealing with the Origin of Grecian Medicine, the Life of Hippocrates, the authenticity of the different treatises ascribed to him, and the doctrines of the various Greek schools of physical philosophy.

No brief review of the teachings of this ancient master of medicine can adequately convey to the reader the keen insight, the meticulous attention to detail, and at the same time the breadth of vision of Hippocrates. A part of his writings, as is to be expected, are amusing in their simplicity. "A woman with child, if it be a male, has a good color, but if a female, she has a bad color." "The male foetus is usually seated in the right, and the female in the left side." Many of his aphorisms, however, have stood the test of time and agree with medical opinions of today. The section on the management of fractures and dislocations is remarkable for its sagacity. Perusal of these writings of the "first physician" is good for the soul.

Pennsylvania Hospital Unit in the Great War. New York: Paul B. Hoeber. 253 pp.

This attractive volume, of which only 1,505 copies were printed, narrates the history of Base Hospital No. 10, U. S. A. The Unit left America May 19, 1917, and taking over British General Hospital No. 16, at Le Treport in June, remained there until February 3, 1919. In the period, June 13, 1917–December 31, 1918, 47,811 patients were admitted to the hospital, and 3,736 operations were performed. Teams were sent to Casualty Clearing Stations, and their work is also recorded in the book.

An excellent picture is given of the routine and amusements incidental to life in such a hospital. Due space is given to the history of the nursing staff; in short, the book is a well-balanced, interesting record of one phase of the war. It is illustrated by numerous photographs.

The Eighteenth Amendment and the Part Played by Organized Medicine. By CHARLES TABER STOUT. New York: Mitchell Kennerley. 216 pages.

To the medical man concerned with the ins and outs of prohibition, as most of us are, the title of this book promises a certain amount of instructive reading. One does not have to read far, however, to perceive that the writer is actuated by an intense personal animosity toward both of the subjects mentioned in the title. Although Mr. Stout is heartily opposed to prohibition, his dislike for it is as nothing compared with his venomous hatred of "organized medicine," as he calls the American Medical Association. Apparently carried completely away by his emotions, he makes numerous absurd statements, so palpably false that they are ridiculous. His arguments in favor of the consumption of alcohol are too futile to recount. Nature has made alcohol essential to the well-being of the human system, he says, and he reiterates this belief in the statement that alcohol is necessary, both as food and medicine, to sustain human life.

His attack upon prohibition is mild compared to his drive against the A. M. A. He begins with the premise that the lack of pecuni-

*See BOSTON MEDICAL AND SURGICAL JOURNAL, Vol. 185, page 61, "Spinal Accessory Paralysis," by the same authors.

ary reward (he favors the idea that a medical man should patent his discoveries) has kept the really intelligent men from going into medicine. In another breath he accuses the leaders of the A. M. A. of plotting a campaign so far-sighted, crafty, and Machiavellian that it leaves us speechless with admiration. By joining forces with the Anti-Saloon League, the Standard Oil Company, and the medical departments of the Life Insurance Companies, the A. M. A., says Mr. Stout, has secured control of alcohol for the benefit of the medical profession, and will later get control, not only of drugs, but of food! He hints, darkly, of some great discovery which will eradicate disease, but which the medical profession has suppressed lest the source of their income should be abrogated. These accusations are directed, not against the general practitioner, but against the leaders of organized medicine who exercise such "crushing disciplinary powers" over him, that he has no independence of thought or of action. A more ludicrous arraignment could hardly be imagined.

A review of *The Eighteenth Amendment*, in the New York edition of *The American Issue* (the organ of the Anti-Saloon League), appears to explain the reason for Mr. Stout's animus.

Charles Taber Stout is secretary and treasurer of the Delson Chemical Co., of Brooklyn. This company markets two proprietary remedies—"Creofos" and "Delcreo." In 1917, the Council on Pharmacy and Chemistry of the A. M. A. reported that the therapeutic claims made in behalf of these remedies were "unsubstantiated and grossly exaggerated." If the aforementioned Creofos and Delcreo were conceived, compounded and marketed under the guidance of minds as ignorant of chemistry, as faulty in logic, as utterly blind to truth as that of the writer of *The Eighteenth Amendment*, it is no wonder they were refused admission to *New and Non-Official Remedies*.

Domiciliary Treatment of Tuberculosis. By F. RUFENACHT WALTERS, M.D., B.S., M.R.C.P., Lond., F.R.C.S., Eng. New York: William Wood and Company.

In this small volume, Dr. Walters has endeavored to cover the home treatment of tuberculosis. It has many good points but also there are various others that are not so good. He is apt to quote from various authorities on both sides of a disputed point, which is all very well as far as it goes. In too many instances, however, he does not give his own opinion, and leaves the reader to decide for himself.

In speaking of trauma and tuberculosis, he makes the statement that cases of tuberculosis following gassing, "have been fairly common in the Great War." From an extensive experience with this subject, I am strongly of the opinion that tuberculosis following gassing is a comparatively rare phenomenon.

He states that consumption is very common among operatives in cotton mills, and gives one to infer that the reason for this is because "The interference with the cooling functions of the skin throws a great strain on the heart, just as happens in heat-stroke." In discussing the present symptoms of tuberculosis, he speaks of a persistent anemia which is probably due to a "wasting of the blood." He likewise speaks of "colliquative" sweats. I am in dense ignorance as to what particular kind of a sweat this is. He likewise states that the albumin sputum test is "useful in distinguishing bronchitis from tuberculosis or pneumonia," and that tubercle bacilli "will sometimes be found in the blood," and that "this is more common in afebrile cases." These statements will not be accepted in this country.

He believes in tuberculin in diagnosis as well as in treatment of pulmonary tuberculosis. In discussing the diagnosis of tuberculosis in children, he dismisses this with a few words that the "physical signs are mainly those of enlarged intrathoracic glands," and likewise, that "Radioscopy is also very useful." He takes up in a very cursory fashion medical indications for home treatment as opposed to treatment away from home. He briefly discusses climate, sea voyages, etc. He gives numerous interesting and practical suggestions in regard to home treatment but leaves out many of the most important details. His chapter on "Precautions Against Infection" is very good although too brief. On the other hand, he gives much more space than is necessary to the use of antipyretics in reducing fever. He goes into considerable detail in the question of diet. In his chapter entitled "Specific Remedies," he again takes up the case for tuberculin to which he devotes more than twenty pages. With one or two exceptions in this country, the feeling is that tuberculin, as far as the treatment of tuberculosis is concerned, might well be omitted. He likewise devotes a fairly long chapter to the value of creosote and other drugs in the treatment of this disease. This chapter, also, might well be shortened, with benefit to the book. On the other hand, what he says in regard to exercise and graduated exercise is excellent.

On the whole, this book cannot be highly recommended. It is neither a short, concise summary of existing opinion nor a textbook going into the details of the various subjects which he takes up.

MOLIÈRE'S TERCENTENARY.

THE Academy of Medicine of Paris has decided to keep the tercentenary of Molière, who is spoken of as the "sworn enemy of charlatans."

The Massachusetts Medical Society

STATED MEETING OF THE COUNCIL, February 1, 1922.

A STATED meeting of the Council was held in John Ware Hall, Boston Medical Library, February 1, 1922, at 12 o'clock, noon. The President, Dr. John W. Bartol, was in the chair, and the following 102 Councilors present:

BERKSHIRE,
Henry Colt.
A. P. Merrill.

BRISTOL NORTH,
Sumner Coolidge.

BRISTOL SOUTH,
W. A. Dolan.

ESSEX NORTH,
F. W. Snow.
R. V. Baketel.
J. F. Burnham.
T. R. Healy.
F. B. Pierce.
R. L. Toppan.

ESSEX SOUTH,
S. P. F. Cook.
W. T. Hopkins.
J. F. Jordan.
E. S. O'Keefe.
W. G. Phippen.
R. E. Stone.

FRANKLIN,
H. G. Stetson.

HAMPDEN,
E. A. Knowlton.

MIDDLESEX EAST,
L. M. Crosby.
F. T. Woodbury.

MIDDLESEX NORTH,
W. B. Jackson.
J. A. Mehan.
M. A. Tighe.

MIDDLESEX SOUTH,
E. H. Bigelow.
E. W. Barron.
Richard Collins.
F. G. Curtis.
C. A. Dennett.
W. E. Fernald.
F. J. Goodridge.
C. E. Hills.
F. R. Jouett.
C. E. Mongan.
C. F. Painter.
W. D. Ruston.
F. G. Smith.
E. H. Stevens.
A. K. Stone.
F. R. Stubbs.
W. S. Whittemore.

NORFOLK,
E. H. Baxter.
D. N. Blakely.
E. J. Brearton.
E. H. Brigham.
A. N. Broughton.
W. L. Burrage.

NORFOLK (cont'd),
F. C. Jillson.
G. W. Kaan.
W. B. Keeler.
Bradford Kent.
M. V. Pierce.
Victor Safford.
G. H. Scott.
Augusta Williams.

NORFOLK SOUTH,
C. S. Adams.
O. H. Howe.
G. H. Ryder.

PLYMOUTH,
R. B. Rand.
W. C. Keith.
Gilman Osgood.
F. G. Wheatley.

SUFFOLK,
F. B. Lund.
S. H. Ayer.
J. W. Bartol.
Robert Bonney
V. Y. Bowditch.
E. G. Brackett.
F. J. Cotton.
L. J. Cummins.
Lincoln Davis.
Channing Frothingham.
J. E. Goldthwait.
W. C. Howe.
J. C. Hubbard.
E. A. Locke.
F. T. Lord.
Donald Macomber
J. J. Minot.
W. H. Robey, Jr.
Stephen Rushmore.
D. D. Scannell.
Myles Standish.
J. S. Stone.
Louisa P. Tingley.
F. H. Williams.

WORCESTER,
J. J. Goodwin.
F. H. Baker.
W. P. Bowers.
W. J. Delahanty.
G. A. Dix.
M. F. Fallon.
Homer Gage.
R. W. Greene.
David Harrower.
E. L. Hunt.
A. G. Hurd.
L. C. Miller.
F. H. Washburn.
S. B. Woodward.

WORCESTER NORTH,
W. E. Currier.
J. G. Henry.
A. H. Quessy.

The record of the last meeting was read in abstract by the Secretary and was accepted. Dr. Donald Macomber, Chairman of the Committee of Arrangements, presented the accompanying program for the annual meeting and it was adopted by vote, without discussion:

REPORT OF COMMITTEE OF ARRANGEMENTS SUBMITTED TO COUNCIL FEBRUARY 1, 1922.

TUESDAY, JUNE 13.

8.30-9.45 Clinics at the various hospitals.

HARVARD MEDICAL SCHOOL
- 10-12 Section meetings, surgery and medicine.
- 12-1.30 Demonstrations of special work done at hospitals, including Forsyth Dental Infirmary and School for the Feeble-Minded.
- 12-1.30 Council meeting.
- 1.30-2.30 Cotting lunch for Councilors, and caterer's lunch for fellows—to be paid for by fellows attending.
- 2.30-4.30 Section meetings, hospital administration, tuberculosis and pediatrics.

BOSTON MEDICAL LIBRARY
- 8 P.M. Shattuck lecture—to be followed by a collation.

WEDNESDAY, JUNE 14.

HARVARD MEDICAL SCHOOL
- 9.30 Annual meeting.
- 10-12 Papers and demonstrations.
- 12-1 Oration.
- 1-2 Caterer's lunch.
- 2-5 Demonstrations and special clinics.

COPLEY PLAZA HOTEL
- 7 P.M. Annual dinner.

ESTIMATE OF EXPENSES OF ANNUAL MEETING SUBMITTED TO COMMITTEE ON MEMBERSHIP AND FINANCE.

Dinner for 700 at Copley Plaza, for which the Society is to pay at the rate of $2.00 a plate	$1400.00
Music at dinner	100.00
Cigars and cigarettes	200.00
Collation after Shattuck lecture, to be held at Medical Library	200.00
Printing programs, postage, printing signs, etc.	300.00
To cover possible deficit at Copley Plaza, or for lunches at Medical School	300.00
Making grand total	$2500.00

DONALD MACOMBER, *Chairman.*

Dr. S. B. Woodward, Chairman of the Committee on Membership and Finance, read this report of his committee, on membership. It was accepted and its recommendations adopted:

REPORT OF THE COMMITTEE ON MEMBERSHIP AND FINANCE, AS TO MEMBERSHIP.

The Committee on Membership and Finance makes the following recommendations as to membership:

1. That the following named Fellows be allowed to retire under the provisions of Chapter I, Section 5, of the by-laws:

Gardner Weld Allen, 419 Boylston Street, Boston.
William Thomas Councilman, 240 Longwood Avenue, Boston.
Douglas Graham, Hotel Brunswick, Boston.

James Joseph McCarty, Minneapolis, Minnesota.
James Cogswell Du Maresque Pigeon, 27 Elm Hill Avenue, Roxbury.
Walter Anson Smith, Box 461, Shelburne Falls.

2. That the following named Fellows be allowed to resign, under the provisions of Chapter I, Section 7, of the by-laws:

Anna Belle Durrie, Mt. Vernon, Ohio.
Henry Bird Fitts, Framingham.
Frank Fremont-Smith, Winter Park, Florida.
Harold Merle Goodwin, Bangor, Maine.
Kamel Khoury, 14 Lake Avenue, Worcester, with remission of dues for 1921.
Harold Myers Marvin, New Haven Hospital, New Haven, Connecticut.
Everett Albert Merrill, 23 Central Avenue, Lynn, with remission of dues for 1921.
Robert Elmer Merritt, Los Angeles, California, with remission of dues for 1920 and 1921.
Frank Leander Morse, 78 Highland Avenue, Somerville.
Frank Thorwald Oberg, Hutchinson, Kansas.
Karl Tristram Phillips, Putnam, Connecticut.
Lionel Alexander Burnet Street, Los Angeles, Calif.
Jonas Hobart Vaughan, Orlando, Florida.
Edward Sawtelle Welles, Saranac Lake, New York.
Frederica Winestine, Helena, Montana.

3. That the following named Fellows be allowed to change their district membership without change of legal residence, under the provisions of Chapter III, Section 3, of the by-laws:

Charles George Barrett, from Worcester to Hampshire.
William Pearce Coues, from Norfolk to Suffolk.
Harold Maurice Frost, from Norfolk to Suffolk.
Lazarus Golden, from Norfolk to Suffolk.
Arthur Ellis Pattrell, from Worcester to Suffolk.
Samuel Maurice Pearl, from Norfolk to Suffolk.
Edward Bernard Sheehan, from Norfolk to Suffolk.
Robert Henry Vose, from Norfolk to Suffolk.

4. That the following named Fellow be deprived of the privileges of membership, under the provisions of Chapter I, Section 8, of the by-laws:

John Joseph Stack, 407 Marlborough Street, Boston.

Respectfully submitted,

SAMUEL B. WOODWARD,
Chairman, Committee on Membership and Finance.

The Secretary read the reports of the committees appointed to consider the petitions of H. L. Flynn and H. L. Wallace to be restored to the privileges of fellowship and each was accepted and its recommendations adopted, namely, that these two petitioners be restored under the usual conditions. The petition of W. H. Blanchard to be restored, being read by the Secretary, the President nominated and the Council appointed the following fellows to consider it: Stephen Rushmore, W. C. Howe, R. H. Miller. In the same manner a petition of T. J. Brennan was assigned to P. E. Truesdale, R. W. French and C. J. Leary.

The President called attention to the importance of the Society keeping in close touch with the American Medical Association; he spoke of having recently attended, with other members of the Committee on State and National Legislation, a regional conference on legislative matters in New York City, arranged by the Council on Health and Public Instruction of the American Medical Association, and he was impressed with the importance of having the Society represented at the coming conference at Chicago by its President, therefore he nominated and the Council elected John W. Bartol as a delegate to the Conference on Health and Public Instruction at Chicago in March, 1922. In a similar fashion, Charles F. Painter, Chairman of the Committee on Medical Education and Medical Diplomas, was elected a delegate to the Conference on Medical Education and Hospitals of the American Medical Association at Chicago in March, 1922.

These delegates to the House of Delegates of the American Medical Association, for two years from June 1, 1922, were appointed:

PRINCIPALS.	ALTERNATES.
H. G. Stetson, Greenfield.	L. A. Jones, Swampscott.
C. E. Mongan, Somerville.	Gilman Osgood, Rockland.
J. F. Burnham, Lawrence.	A. R. Crandell, Taunton.

The Chair nominated and the Council elected the following delegates to the annual meetings of the State medical societies of New England:

Maine: A. P. Lowell, Fitchburg; Richard Collins, Waltham.
New Hampshire: W. E. Currier, Leominster; T. N. Stone, Haverhill.
Connecticut: A. P. Merrill, Pittsfield; G. L. Chase, Clinton.
Rhode Island: C. A. Pratt, New Bedford; G. A. Moore, Brockton.

The Treasurer read the reports of the auditing committee, of the certified public accountant and the treasurer's report, while there were passed about copies of the reconciliation between the profit and loss and budget for the past year, prepared by the accountant. (See Appendix No. 1.)

On motion duly made and seconded it was voted to accept the reports and have them printed.

Dr. Woodward read the report of the Committee on Membership and Finance as to finance as follows:

REPORT OF THE COMMITTEE ON MEMBERSHIP AND FINANCE, AS TO FINANCE.

The Committee on Membership and Finance, before presenting its budget for the current year, wish to call attention to the fact that for 37 years Dr. Edwin H. Brigham has faithfully and efficiently served the Society as its Librarian.

In recognition of this service, and feeling that the time has come when he should, in some measure at least, be relieved of the responsibilities connected with that office, they recommend that the office of Librarian Emeritus be established, that Dr. Brigham be made Librarian Emeritus, that his duties be such as he may elect to perform, other duties to be attended to by the Secretary, and that the salary of the Librarian Emeritus be the same as that at present paid to the Librarian.

They recommend to the Council the acceptance of the following budget for the current year: (see Appendix No. 2.)

The Report of the Committee on the Samuel Fuller Memorial was referred to your Committee by the Council at its last meeting.

While approving, in general, the project, we do not recommend an appropriation of money from the treas-

ury to provide a memorial for the Pilgrim physician, believing that the scheme should be financed in some other way

Although perhaps outside of our province, we suggest to the Council that a Committee of physicians might be appointed by it, authorized to receive such sums as might be given them and authorized also to state that the project meets with the approval of the Massachusetts Medical Society.

The question of the payment or non-payment of the travelling expenses of members of standing committees was considered at length in a report made to the Council at a previous meeting. Had our efficient Secretary unearthed a vote of the Council passed in 1897 before, instead of after the presentation of that report, your committee might have been spared some profitless discussion and you the listening to our somewhat verbose report; for the Council, on February 3, 1897, voted that: "The travelling and incidental expenses of the Society's general officers and of the members of the several standing committees, in the discharge of their duties, be paid from the Society's treasury." This vote seems never to have been rescinded.

Respectfully submitted,

SAMUEL B. WOODWARD,

Chairman, Committee on Membership and Finance.

It was moved and seconded that that portion of the report which relates to the Librarian be accepted, and its recommendations adopted, and it was so voted. The portion relating to the proposed memorial to Dr. Samuel Fuller was discussed by Dr. Myles Standish, Dr. Woodward and Dr. A. P. Merrill, and on motion by Dr. J. S. Stone it was *Voted*, That further action as regards a memorial to Dr. Samuel Fuller be left to the original committee having the matter in charge, in conference with the President of the Society.

The recommendations of the Committee on Membership and Finance as to finance, including the budget, were adopted by vote. Dr. A. N. Broughton said that there were several bills before the legislature on the subject of Workmen's Compensation and he would like to have an appropriation of $500 for the committee of the Society on that subject, of which he was chairman. On motion the request was referred to the Committee on Membership and Finance, under the terms of the by-laws, Chapter IV, Section 8.

Dr. Woodward read a motion as to the investment of the Permanent Fund and the following vote was passed:

Voted, That the Treasurer, Arthur K. Stone, be and hereby is authorized to withdraw deposit of eleven thousand two hundred fifty-three and 30/100 dollars ($11,253.30) with the Massachusetts Hospital Life Insurance Company, represented by its policy No. 97, and he is authorized to receipt for said amount on behalf of the Massachusetts Medical Society.

Dr. Frothingham read a report of the committee appointed last May to consider the medical cults. (See Appendix No. 3.) At the end he suggested that the study inaugurated by his committee should be continued by a comparative study so that necessary data might be gathered that would be of the greatest importance to the medical profession. On motion by Dr. A. P. Merrill it was *Voted*, To adopt the report; that the committee be continued and requested to plan a definite course of investigation and to report further to the Council.

Dr. Homer Gage read the report of the committee appointed May 31, 1921 "to investigate health problems in relation to the care of the sick in rural communities." (See Appendix No. 4.) The report was accepted and its recommendations adopted. Dr. E. H. Bigelow, chairman of the standing committee on Public Health, offered this motion: "*Moved*, That the Council authorize the expenditure of a sum of money not to exceed twenty-five hundred dollars ($2,500) for the investigation of health problems in relation to the care of the sick in rural communities in Massachusetts, to see if conditions can be improved; such money to be expended by the Committee on Public Health, should investigation by said committee demonstrate the need of such work by the Massachusetts Medical Society; all expenditure for this work to be subject to the approval of the president of the Society and the chairman of the Committee on Membership and Finance. The motion was advocated by Dr. Bigelow and seconded by Dr. A. H. Quessy, who drew a distinction between the functions of a state department of health which cares for the conditions governing the health of the community, such as water supply and the prevention of epidemics, and the care of the health of the individual; he thought it the function of the Massachusetts Medical Society to assume the rôle of individual health service—to see that service is given those who need it. Dr. F. J. Cotton and Dr. F. B. Lund thought that the Committee on Public Health should submit a definite plan of proposed expenditure. Dr. W. A. Dolan opposed the motion on the ground that the action would usurp the functions of the State. Dr. Bigelow in response to questions stated that it would lie with the Council whether an appropriation should be made yearly; that it was proposed to employ an able field agent to work under the auspices of his committee. Dr. Merrill advocated publishing in the *Boston Medical and Surgical Journal*, which he thought was more in favor with the physicians of the State and was more widely read than formerly, a definite plan by the Committee on Public Health. *Voted*, That the entire matter be referred to the Committee on Membership and Finance for a report at the next meeting of the Council, with the understanding that the Committee on Public Health will present to said Committee on Membership and Finance, at an early date, a definite, detailed plan for the expenditure of the appropriation asked for.

The Secretary read a letter from Frederic W. Cook, Secretary of the Commonwealth of Massachusetts, concerning the registration of births and deaths, a function of the State which is in charge of the Secretary's office. (See Appendix No. 5.) On motion by Dr. F. G. Curtis this was referred to the Committee on State and National Legislation, after it had been discussed by Dr. J. A. Mehan and by Dr. Curtis.

The President read the following letter from the Berkshire District Medical Society inviting the Society to hold its annual meeting in Pittsfield, in 1923:

PITTSFIELD,
December 27, 1921.

Dr. John W. Bartol,
Boston, Mass.

Dear Dr. Bartol:

Pursuant to a vote which was passed at the last meeting of the Berkshire District Medical Society, the Massachusetts Medical Society is hereby invited to hold its annual meeting in Pittsfield in June, 1923. Although this Society is unable to furnish extensive clinical facilities, we could accommodate the members in hotels and furnish halls for the meetings and depend upon outdoor activity to take the place of the clinics. We should be very glad, however, to hold such clinics as we are able to.

Should the Society accept our invitation we shall be glad to do all in our power to help in making the arrangements and in making the meeting a success.

Very truly yours,

A. P. MERRILL, *Secretary.*

He called on Dr. Merrill who explained how much pleasure it would give the Berkshire district to entertain the parent society; that it would be honored by a meeting in their chief city; that the members planned to have a combination of meetings in the halls and out-door sports; that a suitable hotel was available for the annual dinner. He hoped the Council would vote to meet in Berkshire. Dr. J. S. Stone moved that the invitation be accepted. It was discussed by the Chair, by Dr. Stone, Dr. Lund and Dr. Dolan, and it was *Voted,* That the annual meeting of the Society be held in Pittsfield in 1923; that the matter be referred to the Committee of Arrangements, and that the unanimous and warm thanks of the Council be returned to the Berkshire District Medical Society for their cordial invitation to meet in Pittsfield.

The Secretary called attention to the custom of the Society in the past, whenever it held an annual meeting outside of Boston, to appoint a Committee of Arrangements from the city in which the meeting was to be held, as it was manifestly impossible for a committee of Boston fellows to arrange a meeting in a distant city. Dr. J. S. Stone pointed out that the Committee of Arrangements is customarily appointed by the Council at its annual meeting and that in June a committee can be appointed, on nomination of Berkshire, to arrange the meeting of 1923.

The Chair spoke of the importance of the fellows of the Society making a good showing at the hearings at the State House, then in progress. He referred to the vaccination bills and to the bill for the registration of midwives and called on Dr. J. S. Stone, Secretary of the Committee on State and National Legislation, to say something as to the situation. Dr. Stone said that the members of the legislature are very ready to hear the voice of the medical profession, even if the voice is not harmonious—silence accomplishes nothing; he though that the action of the speaker of the House in visiting the meetings of the district societies in different parts of the State and in contributing articles on medical topics to the official organ of the Society, showed that he is both ready to listen sympathetically and to advance the needs of the profession when they have been made clear by those who are willing to take the time and to devote themselves to the cause. He considered the bill to establish a board of registration in chiropractic a direct assault on the Board of Registration in Medicine—a dangerous bill; town councils should oppose the bill making liable for damages towns where vaccinations are done by the boards of health; outsiders, that is, laymen, must be interested in medical problems in order to obtain results in the halls of legislation. Civic bodies, such as chambers of commerce, can and do accomplish much. They should be approached by the physicians and instructed of the needs of the medical profession.

On motion by Dr. J. Forrest Burnham it was *Voted,* That the Council of this Society instruct the Committee on Medical Education and Medical Diplomas to revise its list of Schools and Medical Colleges of the United States and Canada recognized for the purpose set forth in the By-Laws, Chapter 1, Section 1 (*i. e.* schools, diplomas from which may be received by the censors from candidates for fellowship).

Dr. Lund stated that a special train would carry those who wished to attend the annual session of the American Medical Association at St. Louis in May, leaving the Saturday before the meeting and coming back the Saturday after. He would like to hear soon from those who were planning to attend the session, to the end that they might make reservations on that train.

Adjourned at 2.15 P.M.

WALTER L. BURRAGE, *Secretary.*

APPENDIX TO PROCEEDINGS OF THE COUNCIL.

APPENDIX NO. 1.

REPORT OF AUDITING COMMITTEE.

To the President and Councilors:

We have examined the securities of the Society in the custody of the Treasurer in the vaults of the Bay State Branch of the Old Colony Trust Company; we find them in accordance with the Treasurer's schedule of investments.

The report of audit of the Treasurer's accounts by Horace C. Hartshorn, Certified Public Accountant, for the year ending Dec. 31, 1921, we have also examined and accepted, and submit it herewith as a part of our report.

CHARLES M. GREEN,
RICHARD G. WADSWORTH,
Auditors.

REPORT OF CERTIFIED PUBLIC ACCOUNTANT.

Boston, January 26, 1922.

DR. CHARLES M. GREEN, DR. RICHARD G. WADSWORTH, Auditing Committee, Massachusetts Medical Society, Boston, Mass.

Gentlemen:

In accordance with your instructions I have audited the books and accounts of your treasurer, Dr. Arthur K. Stone, for the year ending December 31, 1921, and enclose herewith,

Schedule A Statement showing the Assets and Liabilities of the Massachusetts Medical Society, December 31, 1921.

Schedule B Statement showing the Current Account of the Massachusetts Medical Society for the year ending December 31, 1921.

The cash on deposit with the banks has been reconciled with the bank statement and found to be correct. Disbursements have been verified, postings to the ledger checked, and trial balance found to be in balance. I have not examined the securities in the safe deposit vaults of the Society.

Respectfully submitted,
HORACE C. HARTSHORN,
Certified Public Accountant.

TREASURER'S REPORT.

SHOWING THE ASSETS AND LIABILITIES OF THE MASSACHUSETTS MEDICAL SOCIETY DECEMBER 31, 1921.

Schedule A.

ASSETS.

Cash:		
New England Trust Co.....	$5,487.99	
Old Colony Trust Co.....	3,688.16	$9,176.15
Investments:		
Shattuck Fund		
Annuity Policy Mass. Hospital Life Ins. Co.....	9,166.87	
Phillips Fund		
Massachusetts 3½% Gold Bonds	10,000.00	
Cotting Fund		
Deposit in Institution for Savings in Roxbury and Its Vicinity	1,000.00	
Deposit in Provident Institution for Savings in the Town of Boston.....	1,000.00	
Deposit in Suffolk Savings Bank for Seamen and Others, Boston	1,000.00	
Permanent Fund		
Annuity Policy of Mass. Hospital Life Ins. Co..	11,253.80	
Massachusetts 3½% Gold Bonds	6,000.00	
Deposit in Franklin Savings Bank of the City of Boston	1,074.48	
Liberty Bonds		
Fourth Issue 4¼% due Oct. 15, 1938—Par value $5,200.00	5,043.23	45,537.88
Total Assets		$54,714.03

LIABILITIES.

Endowment Funds:		
Shattuck Fund (G. C. Shattuck, 1854, Balance, 1866)	$9,166.87	
Phillips Fund (Jonathan Phillips, 1860)	10,000.00	
Cotting Fund (B. E. Cotting, $1,000.00, 1876, 1881, 1887)	3,000.00	$22,166.87
Surplus:		
Balance, January 1, 1921.	$29,426.10	
Year ending December 31, 1921, *Schedule B*.....	3,121.06	32,547.16
Total		$54,714.03

STATEMENT SHOWING THE CURRENT ACCOUNT OF THE MASSACHUSETTS MEDICAL SOCIETY FOR THE YEAR ENDED DECEMBER 31, 1921.

Schedule B:

CREDIT.

Assessments paid to District Treasurers:		
Barnstable	$266.00	
Berkshire	786.00	
Bristol North	618.00	
Bristol South	1,374.00	
Essex North	1,498.00	
Essex South	1,534.00	
Franklin	350.00	
Hampden	2,113.00	
Hampshire	512.00	
Middlesex East	750.00	
Middlesex North	973.00	
Middlesex South	4,788.00	
Norfolk	4,590.00	
Norfolk South	532.00	
Plymouth	978.00	
Suffolk	7,404.00	
Worcester	3,048.00	
Worcester North	784.00	$32,898.00
Assessments paid to Treasurer	$2,185.50	
Less—Return of Overpaid Assessments	15.00	2,170.50
Income Shattuck Fund		435.43
Income Phillips Fund		
Mass. 3½% Gold Bonds		350.00
Income Cotting Fund		
Interest—Institution for Savings in Roxbury and Its Vicinity	45.00	
Interest—The Provident Institution for Savings	45.00	
Interest—Suffolk Savings Bank	45.00	135.00
Income Permanent Fund		
Annuity Policy Mass. Hospital Life Ins. Co.	534.53	
Massachusetts 3½% Bonds	210.00	
Interest—Franklin Savings Bank	48.32	
Liberty Bonds	221.00	1,013.85
Income from Deposits in Banks		
New England Trust Co.	383.11	
Old Colony Trust Co.	102.05	485.16
Total		$37,487.94

DEBIT.

General Expense			
President's Expense	$183.77		
Secretary's Expense	498.29		
Librarian's Expense	119.85		
Treasurer's Expense	233.61		
District Treasurers' Expense	1,875.92		
Censors' Expense	657.13		
Rent	750.00		
Salaries	2,000.00		
Delegates' Expense	139.81	$6,458.38	
Boston Medical and Surgical Journal			
Expense		16,500.00	
Shattuck Lecture		200.00	
Committee Expense			
Of Arrangements	1,046.25		
Publications and Scientific Papers	5.00		
Ethics and Discipline	5.60		
Medical Education and Medical Diplomas	154.63		
State and National Legislation	192.58		
Public Health	684.60		
Health Insurance	15.35	2,104.01	
Annual Dividends to District Societies		6,900.92	
Defense of Malpractice Suits		1,708.20	
Cotting Lunches		396.37	$34,366.88
Balance to Surplus			$3,121.06

Respectfully submitted,

ARTHUR K. STONE, *Treasurer.*

RECONCILIATION BETWEEN THE PROFIT AND LOSS AND BUDGET FOR THE YEAR ENDED DECEMBER 31, 1921.

	Profit and Loss Account	Budget Estimate	Difference Under Estimated	Difference Over Estimated
Revenue:				
Assessments	$35,068.50			
Investments	2,419.44			
Total Society Revenue	$37,487.94	$32,000.00	$5,487.94	
Increase in Revenue over Budget		5,487.94		
Total as per Auditor's Report	$37,487.94	$37,487.94		
Expenses:				
Salaries of Officers:				
Secretary	$1,100.00	$1,100.00		
Treasurer	500.00	500.00		
Librarian	400.00	400.00		
Expenses of Officers.				
President	183.77	200.00		16.23
Secretary	498.29	800.00		301.71
Treasurer	233.61	150.00	83.61	
Librarian	119.85	50.00	69.85	
District Treasurers	1,875.92	1,500.00	375.92	
Censors	657.13	500.00	157.13	
Supervisors		30.00		30.00
Delegates to American Medical Assn.	139.81		139.81	
Rent	750.00	750.00		
Journal	16,500.00	15,000.00	1,500.00	
Defense of Malpractice Suits	1,708.20	600.00		
Contingent Fund		715.00	393.20	
Shattuck Lecture	200.00	200.00		
Cotting Lunches	396.37	400.00		3.63
Standing Committees:				
Of Arrangements	1,046.25	500.00	546.25	
Publications and Scientific Papers	5.00		5.00	
Ethics and Discipline	5.60	25.00		19.40
Membership and Finance		5.00		5.00
Medical Education and Medical Diplomas	154.63	225.00		70.37
State and National Legislation	192.58	500.00		307.42
Public Health	684.60	700.00		15.40
Scientific Papers		100.00		100.00
Industrial Insurance	15.35	50.00		34.65
Dividends to Societies	6,999.92	7,000.00		.08
Total Expense as per Auditor's Report	$34,366.88		$3,270.77	$903.89
Total Budget		$32,000.000		
Expense under-estimated		2,366.88		2,366.88
	$34,366.88	$34,366.88	$3,270.77	$3,270.77
Revenue under-estimated	$5,487.94			
Expenses under-estimated	2,366.88			
Total Gain over Budget (carried to Surplus)	$3,121.06			

APPENDIX NO. 2.

BUDGET FOR 1922.

Income as estimated by the Treasurer		$35,000
Appropriations for expenditures:		
Salaries of officers:		
Secretary	$1,500	
Treasurer	500	
Librarian Emeritus	400	
	$2,400	
Expenses of officers:		
President	200	
Secretary	900	
Treasurer	250	
District Treasurers	2,000	
Censors	700	
Delegates	500	
	4,550	
Rent	750	
Boston Medical and Surgical Journal	16,500	
Malpractice Defense	800	
Shattuck Lecture	200	
Cotting Lunches	400	
Standing Committees:		
Membership and Finance	25	
Ethics and Discipline	25	
Medical Education and Medical Diplomas	230	
State and National Legislation	500	
Public Health	700	
Scientific Papers	200	
	1,680	
Special Committees:		
Health insurance	25	
Maternity Aid	350	375
Of Arrangements for Annual Meeting		2,500
		30,155
		$4,845
Dividend to District Societies		4,000
Contingent Fund		$845

APPENDIX NO. 3.

REPORT OF THE COMMITTEE TO INVESTIGATE THE MEDICAL CULTS.

YOUR committee which was appointed in June, 1921, to study osteopathy and chiropractic, submits the following report in which the subjects of osteopathy and chiropractic will be taken up separately. As the committee found that there was a general lack of appreciation among the members of the medical profession in regard to just what these medical cults signified, some space will be devoted to a description of them.

OSTEOPATHY.

Osteopathy was founded by a doctor of medicine. It depends upon a theory. It is not clear to the committee whether the theory was evolved before some results were obtained from treatment or after. The theory as advanced by Dr. Still, the founder, consists in the belief that the human body contains all of the elements necessary for health, and if the circulation within the body is normal, these elements will maintain health. The impairment of circulation, so that these elements contained in the body cannot be properly supplied to all parts, is the cause of disease. This impairment of the circulation is produced by the action of the vasomotor nerves. These in turn are affected by direct pressure from bones, muscles or ligaments in the region of the spine or by reflex irritation from disturbance in visceral organs or other parts of the body.

In the later books on osteopathy the term "inhibition" appears. Inhibition apparently is the relief of pain and spasm by the application of steady pressure. It is not clear whether this was included in the original theory or added afterwards. According to Still's original theory there is no need for the vast amount of medical knowledge which has been accumulated for centuries, because it is only necessary to discover the lesion which is causing the disturbance in the circulation, correct that and health will result.

Your committee was unable to find any experimental or other scientific evidence in support of this theory, although in recent years an institute for research has been established in California for osteopathic problems. Your committee naturally considers it absurd to throw over all the accumulation of facts that has been produced by medical science for a theory which is unsupported by experimental work or other convincing facts. Your committee further feels that the osteopaths themselves, at the present time, do not feel that this theory should replace all medical knowledge. For it is quite striking to note in the osteopathic literature that the more recent the book, the more use is made of general medical knowledge so far as diagnosis is concerned and the employment of generally recognized therapeutic agents other than drugs. Also it is evident from conversation with members of the osteopathic profession that the rigid interpretation of the old theory is being, in part at least, abandoned.

The question arises therefore, what is osteopathy today? Osteopathy today is really a therapeutic agent which is used for the treatment of any and all pathological conditions. That this contention as to the real nature of osteopathy today is correct seems justifiable from the fact that the osteopathic books speak of osteopathy as a therapeutic agent which is contrasted chiefly with one of the therapeutic agents used in general medicine, namely, drugs. Furthermore, in the State of Massachusetts the General Court has legislated that osteopaths and all others practicing the healing art must fulfil the same requirements in regard to general medical knowledge as regular physicians who desire a license to practice medicine, and having so done they may use any therapeutic agent they wish. Your committee therefore feels justified in looking upon osteopathy as a therapeutic agent and has endeavored to find out the value of this therapeutic agent.

The osteopathic treatment consists in the relief of the so-called osteopathic lesion which is claimed to be present in all diseases. It is important, therefore, to understand just what is meant by the so-called osteopathic lesion. Unfortunately, one forms the opinion from reading that the osteopaths vary somewhat in their conception of the osteopathic lesion, but in general they agree that the lesion consists in certain abnormalities situated chiefly in the muscles, ligaments or joints along the spine. These abnormalities consist of a slight displacement of articular surfaces which may or may not be demonstrable by inspection, palpation or x-ray, a localized tenderness, and a spasm of muscles. They claim that this combination of abnormalities or osteopathic lesion should be found at some point along the spine in practically all diseases. The site of the lesion varies with the localization of the disease. Although they claim that there is some specificity of the lesion so far as location is concerned, there is no specificity of the lesion for different diseases in the same organ. In other words, tumor of the kidney, nephritis, tuberculosis of the kidney and pyelonephritis would all present a similar osteopathic lesion along the spine.

Your committee had an opportunity to see a member of that profession look for the osteopathic lesion in various disorders. In some of them he was able to demonstrate a so-called osteopathic lesion, in others he was not. It seems, therefore, to your committee that the presence of this osteopathic lesion in all diseases is not an established fact. The presence or absence of this so-called osteopathic lesion in disease could be definitely settled, it seemed to your committee, by a careful study of cases by a suitable group of doctors in conjunction with those trained in detecting the osteopathic lesion.

Assuming for the moment that an osteopathic lesion may be present in all disease, what is the method of treatment which is the therapeutic agent peculiar to the osteopathic physician? He endeavors by manipulation and with the assistance of inhibition to reduce the lesion, namely, to correct displacement of the bony surfaces, if any exist, and to relax the muscular spasm and remove the point of tenderness. Granting for the moment that an osteopathic lesion is present and that it may be reduced, both of which presumptions are still unproven, there is no satisfactory proof obtainable that in the great mass of self-limited acute infectious, toxic diseases and incurable chronic disorders this treatment affects the course of the disease. So far as your committee can find, no careful comparative studies have been made on the value of osteopathic treatment in addition to other procedures. Before any claim is justified for the value of this treatment a careful study of a large group of cases should be made in which the usual therapeutic procedures are tried on half the patients and the same procedures plus the osteopathic procedures on the other half.

It became obvious, however, to your committee during their studies that in a group of less well defined conditions, such as lame and painful backs from various causes, etc., the osteopathic treatment afforded marked relief. In this group of cases comparative studies again have not been made, but one is forced to the conclusion, from the great weight of evidence of relief in isolated cases, that benefit is frequently derived by these manipulations. In other instances osteopathic manipulations have resulted in harm to the patient. Your committee en-

deavored to figure out what actually happens in these cases in which relief is obtained, for the osteopaths only have a theory as to the cause of the relief and this theory varies among different osteopaths. A regular physician who has made considerable study of this subject feels that the various theories of the osteopaths do not quite account for the results obtained and offers a different one of his own. Your committee has not arrived at a satisfactory conclusion as to the reason for the beneficial results and feels that at present the reasons are not known. It feels that careful study should be conducted by properly trained medical investigators in order to arrive at the truth in regard to these results.

Your committee in conclusion feels, therefore, that the therapeutic agent known as osteopathy has not been proved to be of any value in the diseases of known pathology. It has been shown to be of undoubted benefit in certain conditions of unknown pathology. It is also well known that it can do harm in various conditions, especially when applied without a general medical knowledge. Your committee urges the Society, therefore, to join with other medical research forces in the State in an effort to clear up the points mentioned above which have not been as yet definitely settled in regard to osteopathy, and to find out in what way osteopathy helps in those very few conditions in which it seems to be of value, in order that this therapeutic agent may be used intelligently by the profession at large. For this purpose funds should be appropriated.

CHIROPRACTIC.

Chiropractic apparently was founded by a layman and, like osteopathy, depends upon a theory. This theory consists in the claim that all disease results from pressure upon nerves as they emerge from the spinal canal. This pressure is caused by abnormal position of the vertebræ. The chiropractor does not need the accumulated knowledge in regard to disease because if pressure is relieved from the nerve roots, health will result irrespective of the type of the disease. One of their leaders, Palmer, says in his writings that he does not want a diagnosis.

In support of this theory your committee has been unable to find any experimental or other sound evidence, either in the chiropractic literature or elsewhere. To substitute this unproved theory for the accumulation of medical knowledge is, of course, absurd.

Your committee is not convinced that the leaders in chiropractic are sincere and feels that the whole subject may be one gigantic fraud in which a certain number of sincere individuals have been carried along. The only possible value that your committee can find in chiropractic is that it may offer a new therapeutic agent which will be of value in certain cases, and therefore your committee has endeavored to investigate the method of procedure used by the chiropractors and study their results.

The procedure of the chiropractor is to examine the spine by palpation and x-rays in order to locate the subluxations or other malpositions of the vertebræ. In addition attempt is made to trace the course of nerves over the trunk, head and extremities for tender points. The chiropractor claims that abnormal positions of certain vertebræ with resulting pressure on certain nerves account for the various disorders known to medicine. Their treatment consists in an attempt to reduce by manipulation these subluxations or malpositions of the vertebræ.

Your committee can find from the chiropractic literature or elsewhere no sufficient evidence that this form of treatment is of any value in disease of recognized pathology. Individual reports on the results of chiropractic treatment in this community are so few that your committee could not find any evidence that this type of treatment is of value in those ill-defined disorders of unknown pathology in which osteopathy is at times of benefit. The tremendous growth of the cult throughout the United States is the one reason for wondering whether in certain ill-defined conditions chiropractic treatment may be of comfort, if not of benefit, to the patients. This point, however, is not proved at the present time and it is quite probable that if any benefit is derived from the use of chiropractic treatment it is the result of suggestion rather than the treatment.

Your committee feels, therefore, in regard to chiropractic that at the most it can only be looked upon as a therapeutic agent in the group of physical therapeutic agents. Your committee feels certain that to employ such a therapeutic agent without general medical knowledge is a great danger to the public health. Your committee urges that the Society include in its investigation of the benefits derived from osteopathy the claims of the chiropractors in order to see if it offers a therapeutic agent worthy of consideration by the medical profession.

Among the various books and pamphlets consulted are the following:

OSTEOPATHY.

Burns, L. J.: Basic Principles of Osteopathy.
Clark, M. E.: Applied Anatomy.
McConnell and Teall: Practice of Osteopathy.
Riggs: Manual of Osteopathic Manipulation and Treatment.
Still, A. T.: Research Institute, Bulletin No. 1.
Research Institute, Bulletin No. 2.
Research Institute, Bulletin No. 4.
Research Institute, Bulletin No. 5.
Taskar, D. L.: Principles of Osteopathy.
Woodall, P. H.: Manual of Osteopathic Gynecology.

CHIROPRACTIC.

Encyclopedia Americana.
Firth, J. M.: Chiropractic Symptomatology.
Loban, J. M.: Technique and Practice of Chiropractic.
McNamara, R. E.: Chiropractic.
Palmer, B. J.: Science of Chiropractic: Vols. II, III, and VI.
Sterns: Methods of Examination.
Vedder, H. E.: Chiropractic Physiology.

RECOMMENDATIONS.

Your committee appointed to investigate Osteopathy and Chiropractic during its work became convinced that the Society owes a duty to the general public in regard to enlightening the public how to handle the growth of medical cults, and therefore has taken the liberty to present to you the following suggestions with the hope that some action will be taken upon them if you see fit.

Your committee feels that the proper way to handle the cult problem, which will always continue to crop up, is to avoid intolerance against the practitioners of these methods, and to educate the public, and especially the legislators, that these cults are in reality simply therapeutic agents. It should then be made clear that all those using any therapeutic agent in the care of the sick should only do so provided that they possess an adequate general medical knowledge, based upon a uniform examination such as the Massachusetts law calls for at present. The Massachusetts Medical Society should always be active in trying to raise the standards of this examination.

CHANNING FROTHINGHAM, *Chairman.*
GEORGE C. BADGER.
JAMES W. SEVER.

APPENDIX NO. 4.

REPORT OF COMMITTEE TO INVESTIGATE HEALTH PROBLEMS IN RELATION TO THE CARE OF THE SICK IN RURAL COMMUNITIES.

The Committee appointed at the meeting of the Council May 31, 1921, "to investigate health problems in relation to the care of the sick in rural communities to see if conditions can be improved," beg leave to report:

The wording of the vote under which this Committee was appointed is perhaps open to more than one interpretation. We may not have taken the one which the proponents of the motion had in mind, but we have assumed that we were not asked to study and report on the health of rural communities. We have interpreted our task to be a report on the means of protecting health and relieving sickness and disability in the country districts of Massachusetts.

The prevention and control of epidemic diseases and the detection and removal of unhealthful surroundings are the functions of the State and local Boards of Health. We have always had and have now an efficient and alert State Department of Health, well managed, quite up to date, and doing an admirable work. We have in rural communities, as a rule, very inefficient local boards, functioning only in the presence of some epidemic or aggravated nuisance; and then only by calling upon the State Department for help. The problem here is one of political organization, and has not changed except for the better for many years. It is doubtful if any practical means could be devised for handling the problem better than it is handled now. So long as our State Department is maintained at its present high standard, and is as actively interested in watching over health conditions in all sections of the State, and is giving assistance wherever it is sought, we believe no radical change in the fundamental plan is necessary. It is possible that the State Department might advantageously establish sub-centers in different parts of the State which should be the headquarters of the district inspector, and where he might be more readily and more quickly accessible to the local boards and the local physicians. If the demand is sufficiently urgent—and we have no accurate data to determine just how urgent it is—this step might be easily taken.

The problem for caring for the sick and disabled in the rural communities is a very different and far more difficult one. Here, however, as in the first problem, we are handicapped by lack of exact, accurate data as to how serious the problem really is. We do know that the number of doctors has not kept pace with the increase in population, that the disparity is growing steadily greater instead of less. We know, furthermore, the number of doctors per 1000 of population has not diminished in the cities, and that the loss must therefore bear most heavily upon the smaller towns. From the data gathered by Dr. Goldsbury, we know that there are many towns in Massachusetts without a doctor; and the survey made in New Hampshire is said to show no doctor in 120 out of 224 towns. It would be very interesting and very helpful if we could have a survey of conditions in this State; and a satisfactory survey ought not to be very difficult or very expensive. It would seem to your Committee that it could best be made by our State Department of Health, with such cooperation as the general profession might be able to lend. Even without this survey, we know enough to make an effort to improve medical conditions in our rural communities imperative if those communities are going to turn out men and women unhandicapped by physical defects and deficiencies. We cannot allow the human product of our country districts to deteriorate for want of proper health conditions. The problem is by no means a simple one; its solution involves two fundamental factors which are beyond the power of the Massachusetts Medical Society to control, but which cannot be ignored.

First, the steady emigration of population in New England from the country to the city, which makes the country less and less attractive to the medical man who is just considering where to settle, and more discouraging to the man who is already settled there. It is pretty hard to persuade the country boy, who has spent four years at college, four years in the medical school, and a year in hospital service, amidst all the allurements of metropolitan life, to go back to the dwindling village from which he came, and still harder to make it look attractive to the city-bred boy. This is the first great handicap to the improvement of medical service in rural communities to overcome, and it is a good deal more than a medical problem. The second is the modern trend of medical education; the time it requires, the expense it involves, and its centralization. We have so raised the requirements for admission to our medical schools that the average country boy can hardly afford to spend the necessary time for his preliminary and professional training; and is still further discouraged by the expense involved. The college graduate in the mass is undoubtedly better material from which to recruit the profession than the country boy in the mass, but there are too many exceptions to be ignored. In Massachusetts, as in the rest of New England, the country boy has quite generally proved himself the possessor of two qualities which, when applied to our profession, have made him unusually successful as a practitioner: resourcefulness and sound common sense. In keeping the country boy out of medicine, the community, and especially the rural community, has been a great loser.

The centralization of medical education in the large cities, with a consequent long period of residence midst the social and financial attractions of city life, is another factor, making it very difficult for the country boy who has been able to fit himself for medical practice, to give them up and go back to the country to live. Now these important factors in our problem—the natural movement of population, and the lack of attraction of general practice—are so far without the control of the Massachusetts Medical Society, that we can hardly do more than focus attention upon them.

There are, moreover, two or three ways in which the influence of the Massachusetts Medical Society may be effectively used to improve the position of the medical man in our smaller communities. For the prevention and control of epidemic diseases the facilities of the State Department of Health and its inspector should be brought in closer coöperation with the practising physician. This may be done by the establishment of local headquarters for the inspector within the district over which he has supervision, as already indicated, and by means of a closer coöperation between the inspector and the local Medical Societies. A regular meeting devoted to preventive medicine should be held by every District Society, and to this the Health Commissioner and Inspector of the State Department should be especially invited. Many minor causes of friction might thus be satisfactorily ironed out and a better mutual understanding promoted.

Another means of helping the physicians in the cities as well as in the rural communities is through the establishment of University Extension Courses similar to those which have been so successfully conducted in Worcester for the past few years. Six or eight lectures are given at intervals of one, two or three weeks by distinguished lecturers from the centers of medical education. The coöperation of the faculties of the Massachusetts Medical Schools is generously extended when asked for, and all that seems necessary is for some to take the initiative in

starting such courses. That the opportunity is open can be given publicity through THE BOSTON MEDICAL AND SURGICAL JOURNAL, and an agency might very properly be designated through which the community seeking such service and the men to render it might be brought together. These courses could be given in different centers and could be made available to the great majority of physicians in our cities and towns without difficulty.

Another means of assisting the medical man in the rural districts would be by a closer coöperation with approved hospitals conveniently located in different districts of the State. Diagnostic clinics could be given in which patients could be received at stated times, given a thorough examination, furnished with probable diagnosis and suggestions for appropriate treatment. Only such patients should be received who are accompanied by their physician or present a letter of introduction from him; and the report on diagnosis and treatment should be sent to the physician, and not given to the patient. To maintain such a clinic requires the presence of a physician at the hospital to conduct such examinations at stated days and hours. If the physicians in the territory tributary to this hospital are sufficiently interested to make the clinic worth while, it would not be difficult to obtain the coöperation of its staff. Should this plan work out satisfactorily the work could be extended to include public clinics at the hospital on certain days, providing what would be really an extension course in clinical medicine or surgery.

Your Committee is aware of the activities of the Standing Committee on Public Health under the direction of Dr. E. H. Bigelow, and realizes that the suggestions herein made are along the lines which that Committee has been following. In spite of the handicap of very much diminished financial resources, that Committee has inaugurated some exceedingly useful work among the District Societies. We believe that they are the logical agency through which such portions of our recommendations as commend themselves to your judgment should be given effective expression. We should therefore suggest that these recommendations be referred to that Committee to be carried out so far as and whenever the District Societies are willing to coöperate, and that an additional appropriation be made to meet the necessary expenses thereof.

HOMER GAGE, *Chairman.*
H. M. FIELD.
P. W. GOLDSBURY.
E. H. PLACE.
E. P. RICHARDSON.

APPENDIX NO. 5.

THE COMMONWEALTH OF MASSACHUSETTS,

OFFICE OF THE SECRETARY,

Division of Vital Statistics,

BOSTON, January 28, 1922.

Dr. Walter L. Burrage,
Eliot Street,
Jamaica Plain, Boston, Mass.

My dear Doctor Burrage:

I wonder if you would be kind enough to present to the meeting of the Council, on Wednesday next, certain aspects of the work of the return by physicians of the vital records of events of which they are in charge. I am trying to bring about a better understanding between the physicians and this office relative to the proper classification of causes of death.

As you know, oftentimes the local registrars have certificates returned to them by this office, and they in turn must go to the physician for a more definite cause of death. A little thought and care on the part of physicians in making out the certificates would save a great deal of time and expense in compiling these very important records. Physicians, of all persons, realize the necessity of as complete a classification as possible and I feel sure that by presenting the matter in this way the coöperation to the end sought will be obtained.

I would also ask if you would be willing to mention the matter of prompt and accurate return of births. This phase of the work is probably in better shape than ever before, but there is still room for improvement. It is not wilful neglect, but carelessness on the part of some physicians which makes the collection of these very important data difficult.

The enclosed form R-17 (Supplemental Report of Birth) if left with the parents would be very helpful in checking up returns in a great many instances, and if the physicians would care to use this additional blank, to be left with the parents for their return, it will not only acquaint the parents with their duty, but will be very helpful in obtaining a complete record of the name of the child. I would be very glad to furnish these to any physician who may care to apply for them.

Assuring you of my appreciation of your coöperation and help, I am,

Very truly yours,
F. W. COOK, *Secretary.*

The Commonwealth of Massachusetts.

SUPPLEMENTAL REPORT OF BIRTH.

NOTICE.—Return this blank, properly filled out, to the City or Town Clerk, or in Boston to the City Registrar.

PARENTS WITHIN FORTY DAYS MUST REPORT BIRTH.

What is the name of your son / daughter born on.....19

Print or type name of child here.....
(First name) (Middle name) (Last name)

REMEMBER YOU ARE RESPONSIBLE FOR RECORDING THIS INFORMATION. SEE LAW ON OTHER SIDE.

Sign your name here.....
(Father or mother)

Your address here.....
and send to the city or town clerk or registrar at once.

NOTICE.—RETURN THIS BLANK, PROPERLY FILLED OUT, IMMEDIATELY.

PARENTS BE SURE TO RECORD THE BIRTH OF YOUR CHILD WITH GIVEN NAME IN FULL.

READ THE LAW!

"Parents, within forty days after the birth of a child, and every householder, within forty days after a birth in his house, shall cause notice thereof to be given to the clerk of the town where such child is born.******" Gen. Laws, Chap. 46, Sec. 6.

SOME OF THE MANY
REASONS WHY BIRTHS SHOULD BE RECORDED

To establish identity.
To prove nationality.
To prove legitimacy.
To show when the child has the right to enter school.
To show when the child has the right to seek employment under the child labor law.
To establish the right of inheritance to property.
To establish liability to military duty, as well as exemption therefrom.
To establish the right to vote.
To qualify to hold title to, and to buy or sell real estate.
To establish the right to hold public office.
To prove the age at which the marriage contract may be entered into.
To make possible statistical studies of health conditions.

YOUR COÖPERATION TO THE END THAT ALL BIRTHS MAY BE PROPERLY RECORDED WILL BE GREATLY APPRECIATED.

NOTICE.—RETURN THIS BLANK, PROPERLY FILLED OUT, IMMEDIATELY.

Current Literature Department.

ABSTRACTORS.

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BACTERIOLOGY AND PATHOLOGY OF FALLOPIAN TUBES REMOVED AT OPERATION.

CURTIS, A. H. (*Surg., Gyne. and Obstet.*, December, 1921). From the clinical history, examination of the external genitalia and evidence obtained at operation, together with laboratory study of the tubes in this series of nearly 300 patients, it has been possible to determine that gonococcal infection was responsible for the pathological changes in over 70% of the cases. Approximately 10% more were thought to have been primarily infected with the gonococcus, but this could not be determined with certainty.

In somewhat more than 15% of these patients the tubal pathology appears to have been entirely due to other pus-producing bacteria, notably various types of streptococci.

Tuberculous tubes, in the absence of generalized tuberculous peritonitis, were encountered in 5% of the cases.

Bacillus coli is particularly frequent in tubo-ovarian abscess of large size. As a primary cause of salpingitis neither the colon bacillus nor the staphylococcus appears to be of notable importance.

It has almost never been possible to obtain gonococci in cultures from thoroughly ground fallopian tubes removed from patients who have been free from fever and leucocytosis for a period of more than ten days or two weeks. The fallopian tube appears, therefore, not to be a focus for chronic gonorrhoeal infection. Persistently active gonorrhoea of the tubes is evidently ascribable either to recurrence of infection from without or repeated invasion of bacteria from the chronically infected lower genital tract.

Tubal infections with various types of streptococci yielded pathological evidence of an active inflammatory process long subsequent to the introduction of infection, and streptococci were occasionally isolated many months, or even years, after the acute process had subsided.

Gonorrhoeal pelvic infection primarily involves the tubes, with resultant thickening, induration, closure of her infection, a single attack of gonorrhoeal salamenable to separation by blunt dissection. Microscopically, the folds of the mucosa are found adherent, pockets of gland-like columnar epithelium extend deeply into the wall of the tube, blood-vessels are numerous, and plasma cells are characteristic.

If the patient can be early isolated from the source of the fimbriated ends, and pelvic adhesions which are pingitis is usually borne without protracted clinical symptoms or severe pathological results. Greatly thickened tubes are most often associated with repeated exposures.

Implicit reliance should not be placed upon haematosalpinx as dependable evidence of tubal gestation. Hæmorrhage may occur in greatly thickened gonorrhœal tubes.

Salpingitis nodosa, although most frequently of gonorrhoeal origin may be due to one of many causes, either inflammatory or non-inflammatory; the microscope best explains the etiology of any doubtful case.

In streptococcus infection tubal involvement is usually but part of the picture. Perisalpingitis is the most frequent type of tubal lesion. Even though there be an extensive salpingitis, the fimbriated extremities will very likely remain open; the mucous membrane folds, or "villi", of such tubes show few adhesions. On the other hand, with the less common occurrence of occluded fimbriae and accumulated fluid within the tube, adhesions are present between the villi and there are nests of columnar cells in the tube wall; differentiation from the gonorrhoeal tube is then difficult.

Tuberculosis is very likely to be overlooked if routine histological preparations are not made. When limited to the pelvic organs it is difficult to establish a diagnosis from the gross appearance alone. Unusually resistant adhesions suggest tuberculous or streptococcus infection.

Somewhat similar operative measures appear indicated in streptococcus and in tuberculous salpingitis. In both diseases infection is not usually confined to the tubes; in both, viable bacteria are often still present in the tissues at the time of operation and there is danger of chronic-postoperative infection of the ovaries. Particularly in regard to extirpation of the ovaries, more radical surgery appears indicated than in gonorrhoeal infections of corresponding severity.

The results of this work again direct attention to the dangers of uterine instrumentation. Nearly all streptococcus infections in this series were traceable to instrumental abortion or subsequent intra-uterine manipulation; some tubal infections recurred after curettage; tent dilatation was followed by streptococcic pelvic abscess. It would appear that the normal uterus and fallopian tubes are comparable with an unopened tube of culture media; passage of instruments through the bacterial barrier of the internal os is analogous to removal of the cotton plug, and nature is not always able successfully to combat infection before serious lesions have resulted. This is particularly true if infection which has been previously introduced is stirred up through subsequent instrumentation. [E. H. R.]

MASSIVE HYPERTROPHY OF THE BREAST.

KEYSER, L. D. (*Surg., Gyne. and Obstet.*, December, 1921), writes as follows:

Massive hypertrophy of the breast is of two types: (*a*) fibroepithelial and (*b*) adipose.

It may occur between the ages of 12 and 48 but is most frequently associated with puberty or pregnancy.

The normal development of the breast seems to depend on the ovary, and there is evidence which strongly suggests that the massive hypertrophy may be etiologically related to an ovarian malfunction.

If spontaneous regression of the process fails to occur, surgical amputation is, at present, the preferred treatment. [E. H. R.]

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HEMATURIA AND THE GENERAL PRACTITIONER.

IN the BOSTON MEDICAL AND SURGICAL JOURNAL of June 17, 1920, appeared an article on the significance of hematuria.* This article was based upon a study of one hundred cases in which hematuria, not due to some obvious cause, such as trauma or specific urethritis, was a prominent symptom. Of the cases studied, thirty-two had infiltrating cancer of the bladder, eleven had massive papillomata and viscus, seven had single small papillomata of that viscus; in eight, the bleeding was due to a hypernephroma; in six, to cancer of the prostate. In 64 per cent. of the hundred cases, therefore, the hematuria was due to a malignant or to a potentially malignant condition. In the remaining 36 cases, bleeding was caused by benign enlargement of the prostate in seven, nephritis in seven, renal tuberculosis in five, hydronephrosis in three, calculus in eight, Banti's disease in three, and, in single cases, by polycystic kidney, diverticulum of the bladder, and papillary cystitis. In no case was the bleeding entirely without significance.

In regard to the cases of bladder tumor, it would be interesting to know how long a time intervened between the first hematuria and the cystoscopic examination by which the diagnosis was made. Too frequently months or even years are allowed to pass before a case of hematuria is submitted to modern methods of study. This is especially true when the hematuria ceases within a few days, or when it is unaccompanied by distressing symptoms. These silent, intermittent hematurias are the ones which are most in need of investigation, for they occur when bladder tumors are young. The time spent in waiting for further signs of trouble may allow a tumor to develop an inoperable condition, and may cost the patient his life.

The multiplicity of urologists and the diagnostic opportunities offered by the larger hospitals make it comparatively easy for the patient to obtain exact information as to the existence of a bladder tumor. No excuse can be offered by the doctor who, seeing a case of hematuria, does not drive home the necessity for taking immediate steps to discover its origin.

Recent comments upon the position of the general practitioner in the medical world deplore his loss of prestige, a loss occasioned, it is alleged, by comparison with the more brilliant career of the specialist. If such loss of prestige exists, may it not be due at times to the assumption by the general practitioner of a knowledge which he does not possess, in declaring of no moment symptoms which later investigation shows to have been signals of danger?

No patient of any intelligence expects his medical adviser to combine in himself the wisdom of half a dozen specialists. He does expect his doctor to direct him to the proper person for examination requiring special training and skill, should the need for such examination arise. Unexplained hematuria always demands cystoscopy.

*The Significance of Hematuria. A Study of 100 Personal Cases. By Arthur L. Chute, Boston Medical and Surgical Journal, Vol. clxxxii, No. 25, pp. 629-639.

MORTALITY FROM SYPHILIS.

KNOWLEDGE of the effect of syphilis on mortality is vague because the apparent cause of death overshadows the morbid underlying and sometimes etiologic influence of syphilis. For example, a person dies from a cerebral hemorrhage and the return of death so specifies, but the ruptured vessel may be the expression of a disease of which the effusion of blood is the end-result. In a series of autopsies conducted in the Central Islip State Hospital, Long Island, N. Y., syphilis was regarded as the direct cause of death in twenty-seven per cent., and as a contributory factor in five per cent. more. Practically one-third of those dying in that institution were syphilitics. It should not, however, be construed from these facts that

syphilis causes one-third of the insanity of the country, for one may argue that the inherent instability in some mentally defective persons led to exposure, and the consequences thereof, but this large proportion of syphilitics does call attention to the importance of this disease in causing death, and should lead to a more scientific record of the etiologic importance of syphilis in reporting causes of death.

The Bureau of the Census, for 1920, records only 7,969 deaths from syphilis in the registration area, and the suspicion of inaccuracy in death returns is leading the United States Public Health Service to seek a basis for preparing more nearly accurate statements of deaths due to this disease.

Even pneumonia, acting as the immediate complication, has been used as a cause of death without qualifying explanation in cases which would have, in time, died of the syphilitic infection. So, also, tuberculosis, chronic nephritis, cancer, and many diseases of the nervous system, have been recorded without the real influence of syphilis appearing in the returns.

Although physicians dislike to put on a death return any statement relating to a disease which may give rise to adverse comment, one ought to remember that statistics are only of value in so far as they are true records; and since most of the intracranial causes of death not due to conditions such as acute infections, lesions of the viscera, and the vascular and nervous systems seem to demand, on the part of the practitioner, more investigations, in order that, when the time comes for filing death returns, the possible incidence of a disease which is far more widespread than is generally admitted, should occupy its true position as a factor in mortality records.

Hospitals are meeting these requirements to a growing degree, but many persons die outside of hospitals, and family physicians should render all possible assistance in the elucidation of problems relating to disease.

VIAVI.

THE MASSACHUSETTS TUBERCULOSIS LEAGUE is asking for evidence which will assist in the prosecution of the agents and manufacturers of viavi. This compound, according to the American Medical Association, is composed chiefly of hydrastis and cocoa butter. The claims made by the company are so extravagant that it may be possible to convince the courts of the fraudulent nature of the assertions put forward.

INCOME TAX FACTS

To avoid penalty, income-tax returns must be in the hands of collectors of internal revenue on or before midnight, March 15, 1922.

Every taxable return must be accompanied by a payment of at least one-fourth of the total tax due. Extensions of time for filing returns are allowed only in exceptional cases, illness, absence, etc. Applications for extensions under these circumstances should be addressed to the collector of internal revenue for the district in which the taxpayer lives. No extension beyond thirty days can be granted by a collector. Requests for further extensions must be addressed to the Commissioner of Internal Revenue, Washington, D. C.

For failure to make a return on time the penalty is a fine of not more than $1,000 plus 25 per cent. of the tax due.

For failure to pay tax when due or for understatement of the tax through negligence, there is a penalty of 5 per cent. of the tax, plus interest at 1 per cent. a month until paid. For making a false or fraudulent return the penalty is a fine of not more than $10,000, or not exceeding one year's imprisonment, or both, together with the cost of prosecution and an additional assessment of 50 per cent. of the amount of tax paid.

NEWS NOTES.

A DEMONSTRATION clinical meeting was held at the Beverly Hospital Tuesday, February 21, 1922. Interesting cases were shown and open discussion followed.

THE Eighteenth Annual Meeting of the National Tuberculosis Association will be held in Washington, D.C., May 4, 5 and 6, 1922. The headquarters, at which all sessions of the meeting will be held, will be at the First Congregational Church, corner of 10th and G Streets N. W. The annual meeting follows immediately after the Triennial Congress of Physicians and Surgeons, which meets in Washington May 2, 3 and 4. No hotel headquarters will be reserved at Washington. Members and others who are attending are urged to make reservations early in view of the meeting of the Triennial Congress immediately preceding and slightly overlapping. The Raleigh, the New Willard, and the Harrington are within five or six blocks of the First Congregational Church.

DURING the week ending February 18, 1922, the number of deaths reported was 245 against 222 last year, with a rate of 16.73. There were 36 deaths under one year of age against 35 last year.

The number of cases of principal reportable

diseases were: Diphtheria, 67; scarlet fever, 60; measles, 123; whooping-cough, 7; tuberculosis, 81.

Included in the above, were the following cases of non-residents: Diphtheria, 6; scarlet fever, 9; tuberculosis, 47.

Total deaths from these diseases were: Diphtheria, 2; scarlet fever, 1; measles, 2; whooping-cough, 1; typhoid fever, 1; tuberculosis, 18.

Included in the above, were the following cases of non-residents: Scarlet fever, 1; measles, 1.

Influenza, 462 cases; 7 deaths.

Lobar pneumonia, 65 cases; 28 deaths.

Dr. S. Burt Wolbach has been appointed *Shattuck Professor of Pathological Anatomy*, succeeding Dr. William T. Councilman, who has resigned.

The death rate from tuberculosis fell 18% in New York City for 1921. This means a saving of 1213 lives as compared with the preceding year. Up to 1919, about 10,000 deaths from tuberculosis occurred each year. Last year the number was 5922. The reasons ascribed to this marked improvement are better sanitation, better living conditions, and the increase of the Jewish population. This race has a high immunity rate as compared with some other races.

Miscellany.

LEGISLATIVE MATTERS.

House 1042 accompanying the petition of Gorham Dana that certain notices be given of the establishment of hospitals and sanatoria, and relative to the licensing and supervision of such institutions, has been referred to the Committee on Legal Affairs for hearing on March 8.

The bill is very long and, though slightly less drastic than a similar bill proposed last year, is definitely directed against private hospitals.

The first section, 73A, would require a state license for any new hospital or any hospital which is not a *bona fide* charitable hospital.

Section 73B grants the Department of Public Health the power to license and inspect hospitals.

Section 73C provides that the local board of health may and that on complaint the Council or aldermen or selectmen shall inspect any hospital licensed as above.

Other sections which follow contain very complicated provisions regarding the securing of licenses, among other matters stipulating that the place, site and building are suitable and will not be injurious to the welfare, health or morals of the community, and that the community will not suffer loss or detriment.

Section 73J provides that in Boston the street commissioners, or elsewhere the aldermen or selectmen, shall be notified of any application for a license and shall hold hearings.

Section 73K provides for advertising in the newspapers and notifying all property owners and residents near the proposed location of the hospital. The next section provides hearings on complaint of any six neighbors.

The bill is complicated, is full of obnoxious provisions, while at the same time it appears to make certain reasonable provisions.

BOSTON ETHICAL SOCIETY.

A dinner meeting of the Boston Ethical Society, devoted to the subject of Ethics in the Practice of Medicine, was held on February 15, 1922, at Hotel Victoria. The speakers were: Dr. L. R. G. Crandon, Dr. I. H. Coriat, Dr. A. Myerson and Dr. W. C. Woodward. Each speaker discussed the subject principally from the angle of his own specialty. A number of interesting points were considered, such as the standard of medical ethics in Greek medicine, the attitude of the physician to his patients, towards other physicians and to the community, the question of privileged communications, and finally, the question of telling the patient the truth.

BOSTON MEDICAL LIBRARY IN CONJUNCTION WITH THE SUFFOLK DISTRICT MEDICAL SOCIETY. GENERAL MEETING JANUARY 25, 1922.

X-RAY TREATMENT OF CANCER OF THE BREAST.

By George E. Pfahler, M.D., Philadelphia.

DISCUSSION.

Dr. L. B. Morrison: We who are doing this work always look to Dr. Pfahler to lead us, and he certainly has. It has been a discouraging work in some respects, because it is a very discouraging disease. In the years that I have been working, and in watching other men, I have seen many encouraging things in this treatment. Many of the cases, after treatment, have had renewed life, and have finally died from a development of the disease internally, without knowing what caused their death. That was worth while. In going over my cases from 1916 to 1920,—about 125 or 130,—it was interesting to see the number of cases that are living and well today, and many of them had rather extensive metastases. It was interesting to compare certain types of cases. I have

in mind two cases sent to me by Dr. Cheever about three years ago. The first was a recurrence which came almost as soon as the patient got out of the hospital. I gave a very extensive treatment, and in three weeks it had sloughed away, with a clean scar. In six weeks, she came back with a cauliflower growth, and died in a very short time. At the same time he sent another patient which he thought was absolutely hopeless, because the operation had been much more extensive. It had been necessary to remove part of the clavicle in order to operate. I gave the patient treatments, and she is living and fairly well today. She has an occasional recurrence in the skin, back of the neck and down over the abdomen, but one dose removes it. Why couldn't we stop the recurrence in the first case? I do not know. It shows that there is a malignancy which takes much more than an erythema dose to kill. So many times recurrences come in the breast while x-ray treatment is going on. Perhaps it is because more doses are required over a definite area. The surgeon can help very much in giving us the location of the disease and in the study of just where metastases most frequently occur, so that we can cover these areas more thoroughly. Occasionally we get low recurrences because, I think, we do not give enough dosage. I was much interested in watching the skin reactions in the pictures shown. Only in more recent years we have dared to get a skin reaction, but we must get this reaction in order to get relief, and it must be severe in the more severe cases. One never knows which case will give a positive result. The pitiful thing is, that after the lesions are cleared up, bone recurrences will be found. I have a patient who is well, as far as can be seen, but every bone in her body is riddled, and she will certainly develop a toxemia. It can be said that many of the treated cases die easily. They fade away with a toxemia, but they die much easier than those without x-ray treatment. The type of cases which Dr. Pfahler has shown are those which involved the deep fascia and are a difficult type to treat. I have a patient in mind who, six years ago, had her left breast removed. Six months later, she came in with two areas of deep skin involvement. I treated her for two years. Now I am treating the other breast. She has had six years of good, useful life, and now she has come back again for a second series over the other side. Pathologists some day will tell us what there is about a malignant growth which requires less dosage in some cases than others.

DR. GEORGE W. HOLMES: I would like to emphasize some of the things that have been said, as they bear out my experience. First, the difficulty in getting definite statistics. We tabulated our cases about a year ago and one of the first difficulties we met was deciding what kind of a case we started with. Before we can get worth-while statistics we must decide what type a case belongs to. This is essential. Then, as we see the cases, we can group them into three main groups: the case where there is no evidence of metastasis. That, of course, is a surgical case. Whether to give pre-operative treatment and post-operative treatment or not is still a question in my mind. Dr. Pfahler would prefer giving them treatment. I am a little in doubt. It means quite a bit for a patient to go through. Just how much we increase the percentage of cures, I am not entirely sure. Second, there is the case where there is no question but that metastasis has taken place and the surgeon is not sure that he has removed the entire growth. In that case, we are justified in treating with x-ray. The third type of case is that which has gone so far that operative cure is impossible. What shall we undertake in such a case as that? If we have a partial operation and x-ray, either before and after, shall we get any better result than with x-ray alone? If so, shall we go ahead with the idea that the patient is to be cured, or are we alleviating the symptoms and prolonging life? I think we can do a great deal in the alleviation of symptoms. We can prevent the carcinoma from breaking down on the surface and making a disagreeable sore, and we can do this in the majority of cases, without making the patient definitely sick. I am inclined, in this group of cases, to aim to make the patient comfortable. Regarding the systemic effect, we know that we can do certain things to the cell. We do not know what we can do to the individual. Is their resistance stimulated by the radiation and does this resistance help to overcome the disease? I think spontaneous cures are not unheard of. The hemoglobin picture improves, the general health improves. Is there any effect on the enzymes of the body? I think this should be considered in the treatment. I would like to ask Dr. Pfahler how often he repeats his treatment. Shall we give one thorough radiation and let the patient go, keeping her under observation, or shall we repeat the dose in three months and again in six months, providing there is no evidence of the disease?

DR. S. W. ELLSWORTH: I would like to emphasize what Dr. Pfahler has brought out, that with all the study done in surgery and in x-ray and radium treatment, still the outcome is very uncertain and any case, apparently, is very doubtful until years have elapsed. That is why we have a difficult problem to meet in the beginning, even in the apparently simple cases. Coöperation of the surgeon, pathologist and the radiologist from the beginning is, therefore, very important. An early diagnosis

is the crucial point in considering prognosis, and for prognosis to be far-seeing the treatment must continue for three to five years to come.

DR. R. B. GREENOUGH: In regard to the pathological classification of these cases, we distinguish a number of different kinds of cancer of the breast, and it is a well-established fact that some of the varieties of the disease are extremely malignant and others are at the other end of the scale. Some cases may show practically no progress for twenty years. We must recognize that certain types of cancer, from their nature and history, are of distinctly slow growth if not interfered with. On the other hand, there are some types, like those in pregnant women, of the lactating breast tumors or of the fibrous structure tumors, which grow with great rapidity; and of adenocarcinoma, which grow slowly in their original location, but which have a very high percentage in the occurrence of bone metastases which appear long after the removal of the original tumor. It makes a great deal of difference in the result as to which one of these types of disease we may be working with. As Dr. Holmes said, it is extremely difficult to get any satisfactory statistics on these cases, because we must have an enormous number of cases before we can get enough data to make our statistics of any particular value. At the present time we are justified in thinking that radiation, either with radium or x-ray, does help and produces very definite effects where it can be brought closely in contact with the lesion. It is the superficial lesion of breast cancer recurrence or the superficial lymph-nodes that are more readily affected by radium and x-ray. The same findings have held true in regard to the use of radium and the radiation treatment of other lesions. Perhaps we may say that the success of the radiation treatment of these more superficial lesions is our best argument that a more effective radiation like that of the high-powered x-ray may well give us control of some of the deeper metastases that we now do not have.

DR. PFAHLER (in closing): First, I believe that every one of these cases ought to be seen by the pathologist, the surgeon and the radiologist conjointly, and then the decision made as to the best course of treatment in that individual case. Secondly, I believe that every case of carcinoma anywhere in the body ought to have radiation and, preferably, before the operation and after the operation. Answering Dr. Holmes, routinely I would advise a preliminary course of treatment requiring about two weeks, and in two weeks the treatment repeated and then ended unless there is some recurrence. This is the present idea. After a time, we will learn more definitely how much we should give. I don't think we ought to keep it up indefinitely. Third, I would like to emphasize the importance of having the patient come back once a month to see that nothing abnormal develops.

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH.

REPORT OF WEEK ENDING FEBRUARY 18, 1922.

Disease	*No. of cases*
Anterior poliomyelitis	1
Chicken-pox	153
Diphtheria	188
Dog-bite	1
Epidemic cerebrospinal meningitis	1
German measles	20
Gonorrhea	78
Influenza	1744
Measles	512
Mumps	149
Ophthalmia neonatorum	10
Lobar pneumonia	253
Scarlet fever	205
Septic sore throat	2
Syphilis	35
Suppurative conjunctivitis	2
Trachoma	1
Trichinosis	5
Tuberculosis, pulmonary	160
Tuberculosis, other forms	18
Typhoid	6
Whooping-cough	127

NOTICES.

THE SPRINGFIELD ACADEMY OF MEDICINE.—On the evening of March 7, 1922, at the Central High School Hall a public meeting, under the auspices of the Academy, will be held for the purpose of emphasizing to the laity the sound, scientific basis on which the practice of medicine rests. The speaker will be Dr. Ernest LaPlace, Professor of Clinical Surgery at the University of Pennsylvania, and a graduate of the University of Paris. He has chosen for the subject of his address, "Louis Pasteur," whose pupil he was for many years.

Members are urged to report interesting cases more frequently.

The Academy wishes to enlarge its membership. Will members please see that every eligible physician receives and signs an application blank?

The January meeting of the Springfield Academy of Medicine was held Tuesday, January 10, with Dr. Hugh Auchincloss of New York City as speaker. Dr. Auchincloss read a paper entitled "Surgery of the Hand." Luncheon was served after the meeting.

ALLEN G. RICE, *Secretary*.

CHILDREN'S HOSPITAL—Clinical Meetings of the Staff of the Boston Children's Hospital will be held in the amphitheatre once a month from November to May inclusive. The meetings will be held on Friday afternoons at 4.30 P.M. All members of the profession are cordially invited to be present. The dates of the meetings are November 4th, December 9th, January 13th, February 10th, March 10th, April 14th, and May 12th.

NEW ENGLAND PEDIATRIC SOCIETY.—The seventy-third meeting of the New England Pediatric Society will be held at the Boston Medical Library, on Friday, March 10, 1922, at 8.15 P.M.

The following papers will be read: (1) Disorders of the Breast in the Early Days of Lactation, Robert L. DeNormandie, M.D., Boston; (2) Unilateral Hypertrophy of the Breast in Childhood, James S. Stone, M.D., Boston; (3) Oral Disorders in Pediatrics, S. A. Cohen, M.D., Boston.

Light refreshments will be served after the meeting.

RICHARD M. SMITH, *President*.
LEWIS WEBB HILL, *Secretary*.

THE BOSTON TUBERCULOSIS ASSOCIATION is planning an Institute for Nurses on the same plan as the recent one by this Association, for Physicians. It is intended to give to the nurses the latest facts with reference to the care of patients with tuberculosis, and speakers from outside the State will supplement home talent. The Institute will be in the hands of a committee including Miss Zepha M. Gardner, Superintendent of Nurses, Boston Consumptives' Hospital, Out-Patient Department; Professor Anne Strong of Simmons College, and Miss Bernice W. Billings, Executive Secretary of the Association. A location central in Boston will be selected for the Institute, the date will be Tuesday, March 21, subject to possible change, and the sessions will be in order both morning and afternoon 7-3t

MASSACHUSETTS GENERAL HOSPITAL.—A clinical meeting of the Staff will be held in the Lower Out-Patient Amphitheatre at 8.15 P.M., Monday, March 13th. Program:

Points Concerning Bile Pigment Metabolism, Dr. Chester M. Jones; Studies of the Causes of Death in Early Infancy, Dr. Eli C. Romberg; Results from Quinidin Therapy, Dr. Louis E. Viko; Metabolism in a Case of Acute Myelogenous Leukemia, Dr. William G. Lennox.

Doctors, nurses and medical students invited.

F. A. WASHBURN, M.D., *Director.*

HARVARD MEDICAL SOCIETY.—The regular meeting was held in the Peter Bent Brigham Hospital Amphitheatre, Tuesday evening, February 28. Program: "The Natural History of Biliary Obstruction." Speaker: Dr. Peyton Rous, Rockefeller Institute.

AT the meeting of the Research Club of Harvard Medical School, to be held on Friday, March 3rd, in the Amphitheatre in Building A, Dr. T. M. Carpenter will talk on: "Metabolism Studies with Enemata of Alcohol, Dextrose and Levulose."

NOTICE OF EXAMINATION FOR ENTRANCE INTO THE REGULAR CORPS OF THE UNITED STATES PUBLIC HEALTH SERVICE.

Examinations of candidates for entrance into the Regular Corps of the United States Public Health Service will be held at the following named places on the dates specified:

Washington, D. C., March 13, 1922; San Francisco, Calif., March 13, 1922; Chicago, Illinois, April 3, 1922.

Candidates must not be less than twenty-three years nor more than thirty-two, and they must have been graduated in medicine at some reputable medical college, and have had one year's hospital experience or two years in professional practice. They must pass satisfactorily oral, written, and clinical tests before a board of medical officers.

Successful candidates will be recommended for appointment by the President with the advice and consent of the Senate.

Requests for information or permission to take this examination should be addressed to the Surgeon General, United States Public Health Service, Washington, D. C.

H. S. CUMMING, *Surgeon General.*

A COURSE IN MEDICINE AND PATHOLOGY AT MASSACHUSETTS GENERAL HOSPITAL.

A COURSE in "Medicine and Pathology" will be given in the Amphitheatre of the Pathological Laboratory by Dr. William H. Smith, Visiting Physician of the Massachusetts General Hospital, and Dr. Oscar Richardson, Assistant Pathologist of the Massachusetts General Hospital.

The complete clinical records of cases coming to autopsy will be presented by Dr. Smith, who will discuss the differential diagnosis. The pathological findings will then be stated, the organs demonstrated and the pathology of the cases discussed by Dr. Richardson. This will be followed by a general discussion of the cases, viewed in the light of the completed records, and attention will be called to the newer diagnostic methods and to the broad principles of treatment involved. Microscopical preparations and lantern slides will be used when necessary.

There will be nine exercises, on Wednesdays, in the months of March and April, between 3.15 and 5.15 P.M.

The course is open to graduates in medicine and medical students of the third and fourth years, subject to their acceptance by the hospital.

Women admitted.

Given in connection with the Harvard Graduate School of Medicine.

A fee of $5.00 will be charged for the course. Application should be made to

FREDERIC A. WASHBURN, M.D., *Director,*
Massachusetts General Hospital, Boston, Mass.

THE American Association of Anaesthetists and the Mid-Western Association of Anaesthetists will hold a joint meeting in St. Louis, May 23-24, at Hotel Jefferson, the first three days of the A.M.A.

DR. JOSEPH GARLAND, of Boston, will give a demonstration of the Schick Test at the Heywood Hospital, Gardner, at 5 o'clock P.M., Thursday, March 2.

RECENT DEATHS.

ROBERT WILLIAM FORSTER, a practicing physician of Lawrence, died there at his home, of pneumonia, February 7, 1922, at the age of 46. He was born in Montclair, New Jersey, October 18, 1875, the son of Robert and Mary Fleming Forster. His education was obtained in the Lawrence public schools and at Tufts College Medical School in Boston, where he graduated M.D. in June, 1900. Settling in practice in Lawrence after he had served as house officer at St. John's Hospital, he conducted an active professional life, becoming obstetrician to the Lawrence General Hospital and entering into the activities of the Lawrence Medical Club, the Masons, Odd Fellows, Knights of Pythias and Merrimack Valley Country Club. He joined the Massachusetts Medical Society in 1901 and was a member of the American Medical Association. He is survived by his widow, who was Miss Grace Chapman of Lawrence, and by a son and a daughter.

JAMES WOODBURY TWOMBLY, a graduate of Harvard Medical School, in the class of 1910, and a practitioner at Stoughton, Mass., died in Boston, February 21, 1922, at the age of 38.

IMPORTANT NOTICE.

Announcement of meetings to be held on and after next Thursday should reach the desk of the Editor of the JOURNAL not later than next Saturday before noon. The printers do not work Saturday afternoon and the material is locked up in the forms on Monday, and goes to press Tuesday morning. The wrapping and mailing begins Wednesday. Please forward copy early.